The MODERN HOSPITAL

Volume 45 SEPTEMBER, 1935 No. 3

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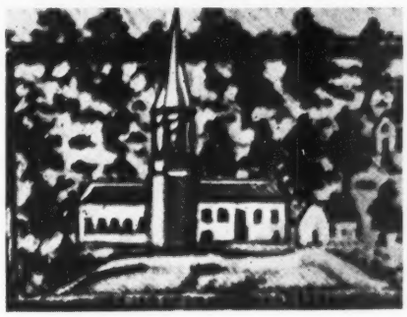
CONTENTS

For September, 1935

Just in Passing—

THE simple belfried wooden building shown here was the first Hôtel Dieu of Montreal. It measured 60 feet by 24. It was founded and erected in 1644 by Jeanne Mance, America's Florence Nightingale, and was used for the care of the sick until 1695 when it was destroyed



by fire. The hospital has been thrice burned down and our cover shows one view of it. It is a general hospital under Catholic auspices where patients of all classes are admitted without regard to race or creed. It now has 350 beds and in 1934 treated 5,802 patients.

AS THIS is being written Congress is trying hard to adjourn. The much discussed tax bill has been passed and the provision curtailing corporation gifts to local charitable institutions has been eliminated. The issue, however, is not dead because this provision was only a surface indication of a fairly deep cleavage in thought between two schools. One school of thought holds that in the long run better service will be given by social institutions that are supported locally and, in substantial part

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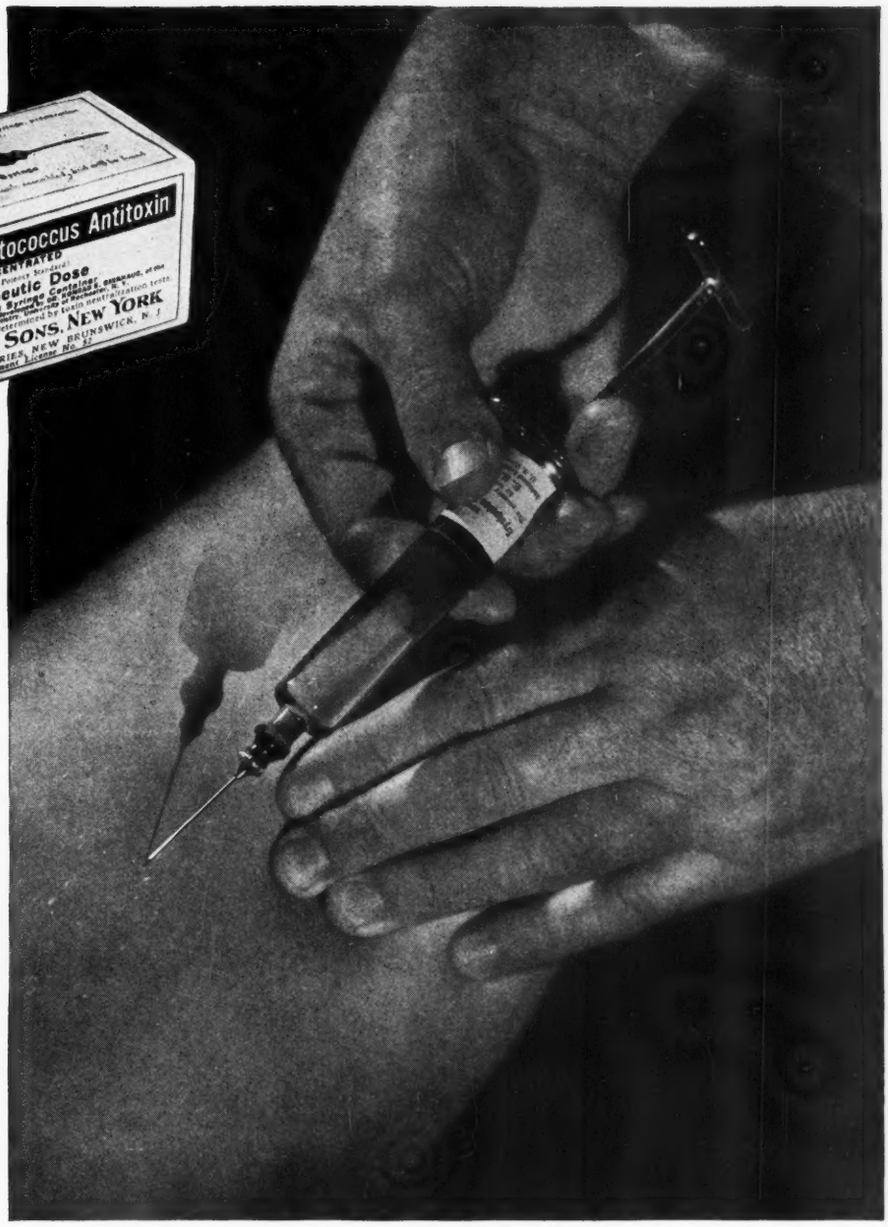
at least, by direct gifts. The other believes that social institutions, because they have a program as broad as the community, should receive their support through the local or national taxing machinery, which is the only plan that brings contributions from the whole community.

During the depression, many of us were attracted by the apparent stability and ease of the second plan. Now comes a vigorous defender of the first. Next month, Charles H. Schweppe, vice president, Lee, Higginson & Co., and president of St. Luke's Hospital, Chicago, will recount some of the forgotten virtues of voluntary support. Mr. Schweppe, you will remember, is the man who has been calling together the trustees of Chicago hospitals to form the Chicago Hospital Council.

IN ONE field there is quite general agreement that tax-supported agencies must dominate. The problem is so large and the funds required are so vast that no one would seriously propose that private effort should take over the care of mental patients. Today over one-half of the hospital beds of this country are devoted to this purpose. Nearly 95 per cent of these beds are provided by governmental agencies, federal, state and local. The problems of these hospitals are analogous to but somewhat different from those of general hospitals.

In order to serve these important hospitals more adequately and to acquaint other hospitals with some of their problems, The MODERN HOSPITAL will inaugurate next month a series of articles on the administration of mental hospitals. This series, which will run in alternate issues over a period of two years, is being prepared under the direction of the committee on public education of the American Psychiatric Association of which Dr. C. C. Burlingame is chairman. The committee has selected twelve outstanding men to prepare this series. It will be a feature of interest to all readers.

LAST month under the heading "A Sober Warning," we published an editorial delicately suggesting that all wide-awake hospital administrators would go to St. Louis for the A. H. A. convention. Woe to an editor when he compliments



We cordially invite you to visit the Squibb Exhibit at Booth Nos. 83 and 84 at the American Hospital Association Convention in the Municipal Auditorium, St. Louis, Mo., from September 30th to October 4th.

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his readers with subtlety! It now appears that a few persons thought we were opposing the convention. Nothing, of course, could be further from our thoughts. If we erred — which we are not yet ready to concede — we did so only by assuming a high I. Q. on the part of our readers.

SOME months ago Dr. R. C. Buerki declared in this magazine that hospital capital dollars were not giving their full service value. Next month the subject is to be considered from a different point of view by Dr. Nathan S. Davis III. Doctor Davis is well able to represent the medical profession as he is the third in a direct line to have achieved national prominence in medical affairs of this country.

IN a cooperative study of staff relationships in 1,332 voluntary hospitals in cities and towns of less than 250,000 population, the A. M. A. and the A. H. A. found that only 73 per cent of the hospitals had organized staffs and 66 per cent had courtesy staffs. The average organized staff in these hospitals consists of 26 physicians and the average courtesy staff of 20. Staff meetings are usually held monthly and over 50 per cent attendance was claimed by 71 per cent of the hospitals having staffs. About half the hospitals invite the courtesy men. On the average, 15.9 per cent of the hospital's patients are admitted by the courtesy staff. In all of these factors there were wide geographic variations.

FLASHES FROM THIS ISSUE:

"By telephoning the principal produce houses and meat dealers for anticipatory prices on fresh vegetables, fruits and meats, and consulting with the storekeeper as to staples and canned goods on hand, one can have a fairly clear picture of what may be expected for the week." *Page 94.*

"Group hospitalization has a community appeal and its sale to the public should be initiated by campaign methods." *Page 44.*

"At least one-third of the surgical patients in Chicago's general hospitals could be adequately served in properly managed and equipped institutions for convalescent care." *Page 56.*

"There are certain basic principles which must apply in the construction of the maternity department of a general hospital." *Page 82.*

THE MODERN HOSPITAL

THE MODERN HOSPITAL PUBLISHING CO., INC.
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RAYMOND P. SLOAN, *Associate Editor*
JANET PETERKIN, *Associate Editor*

No Wonder People Stare ----

Judith and Hilda look refreshingly smart in the capes that Marvin-Neitzel made. There is something about the swing and the drape of these capes that sets them apart from all others.

These alert young ladies, however, wouldn't be so happy if it were only unusual style these capes gave to them. They know from the feel of the fine serge that their capes will look good even after they finish their training — they know this cloth has been especially treated to prevent rain spotting — they know that the price they paid was not a cent more than their capes are worth.

Is it any wonder that Judith and Hilda are pleased—or that people stare when they stroll by

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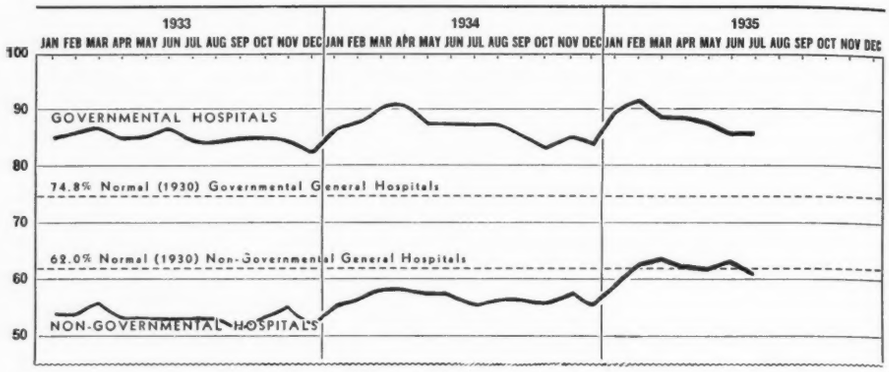


Occupancy in nongovernmental hospitals declined slightly in July but still held over four points above the corresponding figure for 1934. In the governmental hospitals reporting there was practically no change since last month. These hospitals, however, reported a somewhat lower occupancy than in July, 1934, when their facilities were strained by an occupancy of 88.1. Apparently the shift back into nongovernmental institutions is slowly reducing the load on government hospitals.

There was a total of 44 hospital building projects reported from July 29 to August 25, inclusive. Forty of these reported the costs, which aggregated $5,760,860, or an average of $144,000 per project. Four of these were alterations, three of which cost $343,000; there was one nurses' home costing $20,000; ten new hospitals were listed and nine reported costs of $1,089,500. The 29 remaining projects were all additions to existing hospitals. Twenty-seven of them reported costs totaling $4,308,360.

Industrial production during July receded by slightly less than the usual seasonal amount but recovered a considerable portion of this decline during the first half of August, according to the monthly report of the National Industrial Conference Board. The only series among the board's indicators of production to show a greater-than-seasonal decline during July were petroleum, pig iron and bituminous coal. On the other hand, such important indexes as motor production, building, steel activity and electric power output were higher than normal expectations. In general, production continued well ahead of that for the corresponding period of last year.

The general price index of the *New York Journal of Commerce* remained relatively unchanged from July 20 when it was at 79.0 till August 24 when it stood at 80.0 (1927-29=100). Grain prices moved irregularly during this period from 82.6 to 85.9. General food prices, on the other hand, fell slightly and then rose sharply to 86.9 on August 17, the highest point they have reached in several years, but fell to 83.2 the next week. Textiles advanced slightly, then fell again while fuel and building materials declined a little. The price index of drugs and fine chemicals, as compiled by the *Oil, Paint and Drug Reporter*, advanced slightly during August.

Little change in the cost of living as a whole for industrial wage earners was noted by the National Industrial Conference Board for July. The index declined only 0.1 per cent from June. Food prices fell 1.1 per cent and clothing prices a little. Rents continued on their upward trend and coal also showed an advance in price.

OCCUPANCY FIGURES OF HOSPITALS IN VARIOUS STATES AND CITIES

Type and Place	Census Data on Reporting Hospitals[1]		1934						1935						
	Hospitals	Beds[2]	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July
Nongovernmental															
New York City[3]	68	15,194	66.0	62.0	61.0	66.0	68.0	66.0	70.0	72.0	74.0	70.0	70.0*	70.0*	70.0*
New Jersey	58	9,772	61.0	59.0	58.0	60.0	61.0	58.0	62.0	65.0	66.0	65.0	66.0	64.0	64.0*
Washington, D. C.	9	1,782	58.4	59.3	60.7	65.4	65.3	61.8	72.0	71.8	70.5	69.8	68.7	70.6	68.2
N. and S. Carolina	101	5,915	62.6	62.3	60.9	61.1	60.9	56.8	60.6	63.1	64.9	62.3	64.6	66.8	65.3
New Orleans	7	1,198	43.3	52.1	49.5	49.5	47.7	44.9	47.7	49.5	50.1	46.8	50.9	58.3	57.1
San Francisco	15	2,613	56.8	56.9	60.8	64.2	63.2	62.0	65.5	68.2	67.4	69.5	66.4	67.4	62.4
St. Paul	5	807	44.9	45.7	43.4	39.1	45.8	45.8	41.5	53.6	55.9	52.3	48.8	51.7	46.4
Chicago	24	6,163	57.3	59.3	55.6	56.9	57.9	54.5	57.4	57.3	61.9	58.8	55.9	54.7	54.5
Cleveland	7	1,089	60.0	58.4	56.7	57.8	57.7	56.5	61.9	62.0	62.0	63.6	65.7	63.4	61.4
Total[4]	294	44,513	56.8	57.2	56.3	57.7	58.6	56.3	59.8	62.5	63.6	62.1	61.9*	63.0*	61.0*
Governmental															
New York City	16	11,615	91.3	89.5	88.3	89.4	91.0	92.9	96.7	100.6	103.2	104.6	105.6	100.4	103.6
New Jersey	6	2,122	85.0	80.0	80.0	83.0	81.0	78.0	86.0	86.0	84.0	85.0	84.0	77.0	77.0*
Washington, D. C.	2	1,316	79.0	80.2	81.7	78.1	84.8	77.6	86.6	95.5	76.3	72.7	69.4	67.4	68.4
N. and S. Carolina	12	1,241	70.6	66.9	64.0	67.0	68.3	64.7	65.4	65.7	68.5	65.8	68.6	68.1	68.0
New Orleans	2	2,227	148.7	152.4	148.0	129.3	131.6	130.5	144.9	145.4	130.4	130.8	132.8	138.8	145.1*
San Francisco	3	2,255	76.4	77.9	74.4	72.7	78.1	74.2	77.4	79.1	77.1	80.3	77.3	72.3	72.0
St. Paul	1	1,050	69.0	68.0	67.3	66.8	68.5	68.8	74.4	78.7	77.8	75.8	75.2	74.5	67.3
Chicago	2	3,700	84.8	83.7	83.1	84.8	87.0	84.7	89.0	83.4	93.9	84.2	86.0	84.5	83.5
Total[4]	44	25,526	88.1	87.3	85.9	83.9	86.3	83.9	90.1	91.8	88.9	88.7	87.4	85.4	85.6*

[1]Insofar as possible hospitals for tuberculous and mental patients are excluded as well as hospital departments of jails and other institutions. The census data are for the most recent month. [2]Including bassinets, in most instances. [3]Includes only general hospitals. [4]The occupancy totals are unweighted averages. These averages are used in the chart above. *Preliminary report.

THE MODERN HOSPITAL

A Monthly Journal Devoted to the Construction, Equipment, Administration and Maintenance of Hospitals and Sanatoriums

VOLUME 45 SEPTEMBER, 1935 NUMBER 3

The First Fifteen Months

By BASIL C. MacLEAN, M.D.

Director, Strong Memorial Hospital, Rochester, N. Y., Formerly Superintendent, Touro Infirmary, New Orleans

THE press, the platform, the radio and even the movies have been used successfully to explain the advantages of hospital insurance. Much of this publicity, however, has been in connection with programs not yet started or with plans that have barely begun.

Many inquiries addressed to directors of plans in operation are for information regarding financial experiences, percentage of use by various types of subscriber groups, the incidence of hospitalized illness of men as compared with women subscribers, the use of contract coverage of dependents and other data essential to a common sense analysis of the practicability of group hospitalization.

Such inquiries indicate a desire for less theoretical forecasts and more practical results. This article is intended, therefore, to describe the development and use of one plan during its first fifteen months of operation in a city of about 325,000 white population, where wage scales are low, the charity hospital habit strongly entrenched and large industrial units few. The statistics of incidence or load are not offered presumptuously as actuarial data but rather as actual experience. Viewed in this light they may be of some value for purposes of comparison and concept.

To start group hospitalization and in fifteen months have 10,000 contracts covering 40,000 persons—this achievement is to the credit of the Hospital Service Association of New Orleans. And a credit it is!

In 1932, after consultation with Baylor University Hospital, Dallas, Tex., the pioneers in this field, group hospitalization was introduced by Touro Infirmary, New Orleans, as an experiment with three groups of employees—a university, a publishing company and a laundry. On the basis of this experience, the Hospital Service Association of New Orleans was organized in 1933 by the four voluntary general hospitals of the city and, after many legal difficulties and delays, a charter was granted on February 24, 1934, under the Louisiana Industrial Life Insurance Act of 1908 (No. 246). In this incorporation, group hospitalization was defined as insurance, the association was described as mutual in character and the capital was set at $5,000. This amount was advanced as a loan by the participating hospitals.

The board of the hospital service association is

Whether it is being offered to clothiers, insurance employees, bakers or bankers, a skilled and effective

composed of two representatives from each of the four participating hospitals and these eight members elect the other members of the board. Among the latter are the president of the local medical society, the director of the community chest, the president of the association of commerce and representatives of various industrial groups.

In order to avoid competition with hospitals and physicians outside the city, subscribers are accepted only if they reside in the New Orleans metropolitan area.

The contract between the association and the hospitals and among the hospitals themselves is probably the most important document in any hospital insurance plan. It defines responsibilities of the hospitals to each other and to the association, establishes the basis of sales and accounting and provides for the admission of additional hospitals or the withdrawal of a member hospital.

It is agreed in this contract that hospital service shall be rendered by the participating hospitals irrespective of the amount of monies available for payment to the hospitals by the association. The subscriber, therefore, has a protection and a guarantee limited only by the facilities and the financial resources of the participating hospitals. Payment to the hospitals by the association, however, is established at the rate of $4 for each day of hospital service under Type A contracts (ward service) and at the rate of $6 for each day of hospital service under Type B contracts (private room service).

It is provided also that discounts to dependents allowed under hospital service contracts shall be paid by the association to the hospitals. The rates of $4 and $6 a day, however, are fixed, and are all-inclusive for service rendered within the provisions of the subscriber's contract.

In the present plan, the minimum percentages of various sized groups which must subscribe are as follows: no group accepted less than five; groups of 10 or less, 100 per cent; groups of 11 to 50, 75 per cent; groups of 51 to 150, 60 per cent; groups of 151 to 500, 50 per cent; more than 500, 40 per cent.

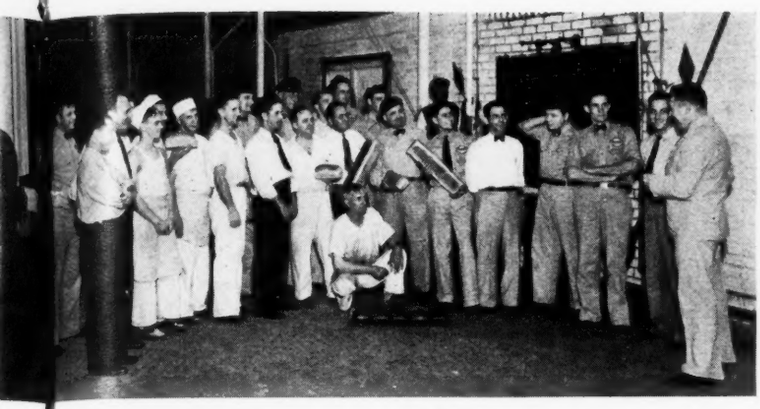
The two types of contract are (a) for service in four to six-bed unit accommodations and (b) private room accommodations. For this, the fee to the subscriber is (a) 75 cents a month and (b) $1 a month. The subscriber may select any one of the participating hospitals at any time and need not designate at time of contract signature, the institution he wishes to patronize.[1] The pa-

TABLE I—SUBSCRIBERS, MEMBER MONTHS AND DAYS OF HOSPITAL SERVICE USED FOR FIFTEEN MONTHS' PERIOD ENDED MAY 31, 1935.

	Subscribers and Member Months	*Days of Hospital Service Used*
March 31, 1934	144	5
April 30, 1934	414	3
May 31, 1934	1,482	30
June 30, 1934	1,674	187
July 31, 1934	2,229	281
Aug. 31, 1934	2,756	138
Sept. 30, 1934	3,107	248
Oct. 31, 1934	3,584	330
Nov. 30, 1934	4,268	270
Dec. 31, 1934	5,009	215
Jan. 31, 1935	5,451	253
Feb. 28, 1935	6,148	440
March 31, 1935	6,700	441
April 30, 1935	7,345	470
May 31, 1935	8,271*	730
Totals	58,582	4,041
Assumed maximum safety limit of days of hospital service per member month		.0833 Day
Actual days of hospital service per member month		.0690 Day
Days of hospital service under assumed maximum limit		.0143 Day
Total number of subscriber patients for period:		
Patients discharged prior to 5-31-35	496	
Patients in hospital as on 5-31-35	22	518
Total number of dependent patients for period		807
Total days used by dependents for period		4,893
Average number of dependents per subscriber		3
Total number of groups written		439
Average number of subscribers per group		18

*The number of subscribers on August 10 was 10,003 and since there is an average of three dependents for each subscriber the total number protected was about 40,000. This does not include the Negro subscribers to the Flint-Goodridge plan.

[1]Negro patients are not accepted by the Hospital Service Association but the same contract is available to them from Flint-Goodridge Hospital and is sold by the same selling staff. The money for these subscriptions is handled entirely by the Flint-Goodridge Hospital. On August 10, 1935, there were 552 contracts with Negro subscribers in force.



presentation of the group hospitalization scheme by carefully trained representatives is necessary.

tient may also, of course, select his own physician although it is stipulated that such physician must be acceptable to the hospital at the time admission is requested. Patients are accepted only on reference of a physician. The contract provides use of operating room and pathologic laboratory without charge, excludes service of attending physician, surgeon or anesthetist but allows a discount of 33⅓ per cent on all hospital services not designated, for example, x-rays and basal metabolism tests. The period or periods of hospitalization in any one year must not exceed twenty-one days in total but all days in excess of this period are granted a discount of 33⅓ per cent. The usual restrictions in case of epidemic or other public disaster are provided.

TABLE II—MALE AND FEMALE PERCENTAGES

	Subscribers	*Subscribers Hospitalized*	*Patients*	*Patient Days*
Male	62	4.08	49	45
Female	38	6.98	51	55

A feature of the contract is the provision of a discount of 33⅓ per cent from regular rates to any member of the household or other dependents of the subscriber. This family discount provision has been abused and it is suggested that dependents should be limited to wife or husband and minor children of the subscriber.

It was assumed that the maximum load for financial or actuarial safety would be one hospital day per member per year or .0833 (1/12 of 1) day per member per month. Table I illustrates the experience under this plan.

During the first fifteen months the hospital service association has paid $22,976 to the participating hospitals for care of subscribers and has paid or credited these hospitals with a total of $14,639.39 refund of the 33⅓ per cent allowances to dependents. The number of semiprivate (A) contracts sold was 1,728, or 21 per cent, with 4.4 per cent cancellations. The number of private (B) contracts sold was 6,543, or 79 per cent, with 2.8 per cent cancellations. The high percentage of Class B contracts indicates that this plan has not yet penetrated low wage scale industrial groups. The extremely low lapse ratio, however, may be ascribed to the same cause.

It is apparent from Table II that our experience like that of other group hospitalization plans, indicates that women cost far more than men. Although the men subscribers outnumber the women, sixty to forty, there actually were more women patients and they had longer average stays. The cost ratio in terms of patient days would be one woman subscriber costs as much as 1.99 men or almost twice as much as one man subscriber.

Only 3 per cent of the subscriber patients exceeded the twenty-one-day maximum hospital stay period and the average length of the excess for this 3 per cent was six days.

The average payment for hospital care by the association per 12 months' contract was:

Subscribers	$4.12	
Dependents	2.34	
		$6.46
Sales Cost		2.00
		$8.46

That the rates charged ($9 and $12 a year) are sufficient to meet present costs in spite of a certain amount of abuse in connection with the discount to dependents is indicated by the above figures. As the percentage of renewals (on which

TABLE III—COMPARISON OF LOAD BY VARIOUS EMPLOYEE GROUPS

Department store employees	.0839 day per member month
Telephone company employees	.0838 day per member month
School teachers	.0771 day per member month
Industrial company office employees	.0584 day per member month
Bank employees	.0362 day per member month
Insurance company employees	.0282 day per member month

the sales cost is lower) increases, the margin of reserve may also increase. Table III indicates the wide variation experienced by different groups. Some of these differences, of course, may be fortuitous and may iron out after more extensive experience with larger numbers covered.

Much has been written about the danger of exploitation by commercial sales intermediaries.

The public considers group hospitalization its own property, hence public and newspaper support is generous.

More might be said regarding the futility of amateur or inexperienced sales direction. Group hospitalization has a community appeal and its sale to the public should be initiated by campaign methods. This demands a special type of organization and in the program described in this article sales were intrusted to a company specializing in community chest and similar campaign work. Control of policy rests with the board of the association, however, and high pressure sales methods have been unknown.

Talks to luncheon clubs and other similar groups, the generous but judicious use of circulars in all outgoing hospital mail, distribution of circulars by nurses in department store booths, a movie strip in local movie houses, news reels and a few supplemental news items have constituted in the main the advertising of the plan. The old slogan "satisfied customers make the best advertising" has proved to be true and each contract holder who receives hospital care is given a "sticker" such as is illustrated here.

The check off system or pay roll deduction is fundamental to simplicity of accounting and economy of collection. In some groups where employers still oppose this method, an appointed group treasurer collects and remits fees but it is hoped in time that pay roll deduction may be the exclusive method.

It may be thought that hospital employees offer an ideal nucleus for multi-hospital group plans. One such group was accepted by the Hospital Service Association of New Orleans as an experiment. The experience has been as follows:

Patient Days per Member Month..... .3142
Patient Days per Member Year.....3.7704

This is almost four times the assumed maximum safety load and almost five times the ratio of general membership average.

It may be concluded that in a cooperative hospital plan the inclusion of hospital employee groups may be a temporary financial advantage to the thirsty hospital but disastrous to the treasury well of the association. It is suggested, therefore, that such groups be covered by individual hospitals since the hospital employee when ill does not need the association privilege of selection of a hospital.

By comparison of experience and by an analysis of statistical and financial studies, better actuarial data should be obtained. The advice and assistance of Dr. C. Rufus Rorem as consultant in group hospitalization to the American Hospital Association have been extremely valuable and the success of hospital insurance plans everywhere will depend on sound administrative practice. Group hospitalization is not a philanthropy or a panacea but it is the most promising development in hospital economics in our generation.

All has not been smooth sailing with the New Orleans plan. Problems have arisen with the patients, the hospitals and the medical profession. But these have been faced in an honest and sincere manner.

A Committee Looks at

The Central Admitting Office

This report to the medical staff of the hospital of the University of Pennsylvania by its out-patient committee interprets information gathered by a questionnaire and makes recommendations regarding the admitting unit, its layout and personnel*

ON TWO occasions, two years apart, members of the medical staffs of the Hospital of the University of Pennsylvania, Philadelphia, have recognized the importance to hospital organization and function of a central admitting unit for the reception and distribution of patients to the various departments of the hospital.

A previous problem in hospital administration (the central unit record system) had been analyzed with reference to American practice through the splendid cooperation received from a number of hospitals in the answering of a comprehensive questionnaire.[1] The hospital's out-patient committee believed that it might once more crave indulgence for a similar method of approach to the problem of a medical central admitting unit, and this summary report is both a recognition and an expression of appreciation for the cooperation again received.

As in the first study, hospitals were selected approximating the Hospital of the University of Pennsylvania in size, type of organization, and teaching responsibilities. The development of a questionnaire, while painstakingly attempted, proved, however, much more difficult than in the case of the central record system, to judge by the number and clarity of the replies.

The efforts of those in charge of hospital organization who did attempt to satisfy in detail our none too well expressed inquiries, are therefore the more appreciated. To 65 questionnaires sent out, 48 replies were received. The material was repeatedly subjected to scrutiny from various angles by the committee, individually and as a whole.

Admitting Unit Is Defined

We define the central admitting unit of a hospital as a professional and administrative group concerned with the admission and distribution of patients, including or excluding out-patients as the case may be. This group may or may not have a stable personnel and organization, and may or may not have its own physical plant and equipment within the hospital itself. By the central admitting officer we mean the executive head of this group, be that person physician, lay administrative officer, social worker, nurse or clerk.

Portrait of a Central Admitting Officer

Nineteen of 32 hospitals replied affirmatively to the question "Do you have a central admitting officer?" and 13 negatively. Inasmuch as variations in the extent to which the questionnaires were answered on various particulars have introduced shifts in figures, it is believed best to use a percentage nomenclature for vividness and to avoid discussion of the exact number of replies to each question. In estimating the significance of figures based on questionnaires, we believe there will be a swing towards the positive side which must be considered in weighing them. Accordingly the following general statement is offered.

Sixty per cent of 32 answering hospitals had a central admitting officer. In an equal proportion of 22 hospitals he is a permanent officer of the hospital staff, and likewise in 60 per cent of 19 hospitals he is a recent graduate. In only two instances is the office filled by an available man from the visiting staff on rotation.

This officer is equipped with an office of his own in 80 per cent of cases, and in practically all cases has a waiting room and an examining room as part of his suite. The actual and theoretical set-up of the central admitting unit is separately discussed.

The record of an entering patient begins in the

*The members of the committee are: John H. Stokes, M.D., chairman, L. Kraeer Ferguson, M.D., John C. Gittings, M.D., Richard A. Kern, M.D., I. S. Ravdin, M.D.

[1]What Sixty-Six Hospitals Think of the Central Unit Record System, The MODERN HOSPITAL, Jan., 1933.

central record room at the time he is seen by the central admitting officer in 81 per cent of 27 hospitals. Complete examinations of the patients are made by the central admitting officer in 76 per cent of 25 hospitals, and in a similar proportion of cases he takes notes of the patient's history. His history and examination become a permanent part of the records in 21 hospitals. In 73 per cent of 22 hospitals, the central admitting officer examines all patients who are admitted to the wards, and in an even larger proportion, 85 per cent of 20 hospitals, examines all patients who are re-admitted to the hospital for re-diagnosis.

On the other hand his relation to the out-patient department is by no means so close. In only 27 per cent of 18 hospitals does he examine patients for out-patient department admission. Direct admission to the wards takes place through the central admitting officer in 74 per cent of 27 hospitals, and only rarely (10 per cent of 23 hospitals) is he expected to call consultation before such admission takes place.

The importance and personnel attached to the post of central admitting officer can be inferred from the accompanying table of staff personnel supplied by answering hospitals.

PERSONNEL OF CENTRAL ADMITTING OFFICE

Personnel	*No. of Hospitals*
1-5	8
6-10	5
11-15	3
34 and over	1
Full-Time Doctors	
1	3
2	5
3	2
7	1
Part-Time Doctors	
1	1
2	4
3	1
10 or over	1
Nurses	
1	6
3	1
5	2
7	3
Orderlies	
1	2
2	1
3	2
4	1

One hospital has additional personnel of 8.

In order to form a rough estimate of the size of hospitals to which the foregoing considerations apply, it was found that the total new admissions per year in the out-patient departments of the hospitals in question ranged from 1,200 to 160,000 patients, with a mean of 38,000. The total in-patient admissions per year in the same group of hospitals have a mean of 18,000.

The relation of the central admitting office to the determination of the financial status of the patient was considered in two questions. It was apparent that in only a small proportion (35 per cent of 26 hospitals) was the central admitting officer expected to determine the financial status of the patients. In no instance did a medical officer exercise such jurisdiction.

An important question of medical policy and human relationship, namely, the practice of having the patient meet either a medical or a fiscal officer as his first contact with the hospital, met with an interesting reply. Ten hospitals frankly establish contact with their patients through a fiscal officer in advance of medical examination. Twelve hospitals, on the other hand, consider the medical situation of the patient first, and establish their first contact through a medical officer. In 9 hospitals the practice was variable and from 17 hospitals no answer was received. All the information obtained shows that financial arrangements with patients are made by fiscal officers of the hospital or by trained social service workers, and not by physicians.

The hours of service of a central admitting office must, of course, vary with the character of the hospital, but it was interesting to note that prevailing practice calls preponderantly for twenty-four-hour service or at least that the services of the central admitting office shall be available on call.

The provision of consultation for the central admitting officer with staff members in doubtful cases is a well recognized feature in central admitting office practice, and nearly 70 per cent of hospitals with central admitting officers provide for it. The question of disposal of ward patients referred by staff members drew replies indicating that the overwhelming proportion of the 25 answering hospitals passed such patients through the central admitting office (92 per cent), and the central admitting officer has complete jurisdiction as to the reference of individual patients to individual services in 77 per cent of 26 hospitals. When a patient is referred to the hospital with the request that he be placed on the service of Doctor Doe, 50 per cent of 22 hospitals grant this request if the diagnosis is correct, and 50 per cent refuse the privilege of such outside reference.

Central Admitting Budget

In the 17 hospitals having a budgeted admitting staff, there are two general types of direction.

1. Ten hospitals have a medical admitting officer, who is a full-time member of the staff and frequently has one or two assistants. In one large municipal hospital there are five physicians serving in this capacity. As a rule, the admitting physician is provided with clerical help, as well as

orderlies, nurses, and, in some cases, maids. The salary of the central admitting officer ranges from $1,200 per year with maintenance to $3,000 per year. The average stipend is about $2,000 a year with maintenance, but the mean figures would lie between $1,500 and $1,800 per year. The total annual budgets of these ten admitting departments range from $1,620 to $52,294 with a mean average of $16,520. The hospitals in this group include four large municipal hospitals in which teaching activities are carried on, four other teaching hospitals in large cities and two other large urban hospitals.

2. In seven hospitals a trained social service worker, a nurse experienced in admission work, or an executive assistant of the superintendent acts as admitting officer. In those hospitals the number of such admitting officers varies from two or three to five, and there is the usual staff of clerks and nurses. The salary of the social service worker varies from $1,800 per year with maintenance to $3,600 per year. In this group are included six large teaching hospitals in urban centers.

In all cases except one the budget for the central admitting officer and his staff comes from the general hospital fund.

Admissions and Emergencies

It appears that in-patients were admitted to the answering hospitals (29 in number) as follows: in 17 per cent of the hospitals by a full-time medical officer or assistant medical superintendent; in 45 per cent by resident, assistant resident or surgical fellow (one hospital); in 20 per cent by an intern; in 10 per cent by a lay clerk or assistant director; and in 7 per cent by the staff of the emergency ward or out-patient department.

Admissions of new patients to the out-patient department were made as follows: in 50 per cent by a nurse, social service worker or by lay personnel; in 20 per cent by a full-time medical officer or assistant medical superintendent; in 20 per cent by a "pre-clinic" or diagnostic clinic, and in 10 per cent by an administrative officer without examination.

The information covering this item of our inquiry is less satisfactory than other phases, probably because of shortcoming in the wording of the inquiry. Nonetheless it appears that in 72 per cent a medical officer, most often a resident, is responsible for the admission of in-patients while out-patients are admitted by a nurse, social service worker, or lay personnel in 50 per cent of the answering hospitals. When the chief admitting officer of the hospital is a physician, he or his staff is in charge of the receiving ward and passes upon all cases requiring admission to the house. In this capacity of supervisor of the receiving ward he directs the treatment of all emergency cases. In other hospitals where the admitting officer is not a physician, emergencies are cared for by hospital interns or by the senior residents of the house staff.

Physical Plant and Layout

The duties of a chief admitting officer of a hospital evidently vary widely in accordance with the work of the hospital and its clientele. In general, especially in the larger hospitals, the chief admitting officer will have responsibilities involving a number of closely related departments. His administrative responsibility will be large, and the set-up and physical equipment for his work should reflect and be governed by the extent of those responsibilities.

Twenty-seven hospitals answering our questionnaire gave answers indicating that the chief admitting officer should be placed in close proximity to the receiving ward and the out-patient department. Many of them stated that his office was so situated that he also had easy access to the wards, although in the opinion of the committee the former is the more important consideration. Since in most of the answering hospitals the chief admitting officer was responsible for the conduct of the receiving ward, it is evident that his office should be so situated that either he or one of his medical assistants can be in constant touch with it.

In fifteen of 24 hospitals answering the questionnaire the admitting office was also in close proximity to the out-patient department. This is important if the chief admitting officer and his staff are to be held responsible for the allocation of patients to the proper out-patient clinic. It appears that since the first contact of the patient with a medical officer of the hospital is made at the time of application for in-patient or out-patient service, it is necessary that this contact be made in an atmosphere that permits of privacy and tends to encourage confidence in the hospital organization.

In 14 instances (29 hospitals supplying no information) it was possible to obtain a theoretical cost per new patient figure by estimating (a) the salaries of the personnel listed in the questionnaire; (b) the salary of personnel implied in the questionnaire, that is, whenever a fiscal officer was not mentioned among admission personnel, but when it was also stated that "finances were arranged through a fiscal officer," the estimated salary of such a fiscal officer was included; (c) the cost per admission obtained by dividing this estimated total cost by the number of new pa-

tients admitted. But this figure is again open to great error — perhaps 100 or 200 per cent — since it is not always clearly stated whether the admission personnel takes care of admissions of both in-patients and out-patients. Furthermore, it is not always made clear that the personnel involved are employed wholly in the work of admissions.

Bearing these inadequacies in mind, one may nevertheless get some idea of costs. The estimates range from $0.19 to $1.13 per admission, the figures being respectively $0.19, $0.26, $0.34, $0.34, $0.39, $0.42, $0.45, $0.46, $0.47, $0.52, $0.55, $0.57, $0.73, $1.13, with a mean of 0.49. In general, the larger the number of patients handled, the lower was the average cost per patient; thus the lowest figure ($0.19) was arrived at in the institution which admitted the highest number of patients.

The cost was not appreciably influenced by whether a physician or physicians were included in the admission personnel, since usually the salary paid a physician was not greater than that paid to social workers. In fact, the highest cost per patient ($1.13) was in an institution whose admission personnel consisted only of nurses, orderlies and maids.

In only 5 cases did hospitals give enough information to arrive at a fairly accurate estimate of cost. It is significant that all of these are large city owned institutions, with large numbers of patients per year, well organized financial structure and long years of experience. The figures of cost per patient in this group are $0.58, $0.78, $0.84, $0.93 and $0.93. These figures are distinctly higher on the average than those for the preceding group. This is, however, due in part to the greater accuracy of the figures, and in part to the fact that these institutions have some form of receiving ward and emergency service administered by their admission personnel.

The Committee's Recommendations

The effort of the committee to interpret the information which it has accumulated and the consideration of its applicability to the Hospital of the University of Pennsylvania and to hospital conditions generally, leads it to formulate recommendations regarding the central admitting unit in general and its personnel in particular.

It is realized that the problem is essentially one for local determination, and that local conditions and physical plant will have an important if not decisive influence upon the post, equipment and incumbents. Nonetheless, it appears to the committee that a central admitting unit has been demonstrated to be a practical and useful, if not an essential, part of the organization of our larger hospitals. It is conceded that some differentiation may be made between teaching and nonteaching hospitals and between hospitals having relatively large in-patient or relatively large out-patient services.

The central admitting unit is a logical accompaniment of a central record system, and where the two may exist together the central record should begin in the central admitting office. It is recommended under such circumstances that special space on the cover sheet of the central record shall be reserved for the central admitting officer's findings.

The conclusions of the committee as to the physical quarters and their placement may be summarized by the statement that location in close proximity to the receiving ward and the out-patient department of the hospital is the most desirable arrangement. In fact, it is a proper question whether the receiving ward of the hospital should not be an integral division of the central admitting unit and under the direct charge of the chief admitting officer. The physical plant of the central admitting unit should provide adequate waiting room facilities and small examining and history taking rooms in which it is possible, with a maximum conservation of space, to secure likewise maximum privacy and consideration for the patient as an individual.

Is an Isolation Unit Necessary?

The question as to whether or not the central admitting unit as part of its receiving ward should contain quarters for isolation of one or at most two suspected infectious cases, will, of course, be governed by the facilities of the hospital with reference to the care of infectious diseases in general. It may, however, be pointed out that the shorter distance through which a suspected infection travels after it enters the portal of the hospital, the less is the risk of dissemination and, in many particulars, the simpler the problem of management. An isolation unit in the receiving ward may well be regarded as comparable in importance to the isolation cubicle of a pediatric ward. If such a unit is provided it should be equipped for the best type of aseptic nursing and medical management.

There appears to be no valid reason, once a hospital has planned for a central admitting unit in conjunction with a central record system, why all out-patients as well as in-patients should not pass through this unit before distribution to the individual out-patient clinics or to the wards. Such centralization permits of adequate tracing of responsibility and error, minimizing the latter because a general medical survey is the logical predecessor of the various special examinations.

In particular, the errors for which a nonmedical person may be responsible in an attempt to place an acute or emergency problem by an over-the-counter inquiry regarding leading symptoms, are, it seems, too obvious for discussion.

Chief Officer Should Be Physician

The committee is prepared to take the stand that the chief admitting officer of a central admitting unit should be a physician, and that it is desirable that the first contact of an entering patient be with a physician rather than with a nurse, social service worker or fiscal officer. Nothing can quite take the place of the right of the ailing human being to bring his medical complaints with the utmost directness and expedition to medical decision and judgment. When circumstances make it possible, the committee feels that the central admitting office should be considered primarily as a medical unit of the hospital rather than as a business or administrative division.

Whether or not the chief medical officer of the admitting unit shall be on full time or part time must be determined by the volume of work and responsibility which he is asked to assume. Where such responsibilities are large the possession of a medical degree alone is not in itself sufficient qualification for the position, but in addition to an adequate medical training and internship the chief admitting officer should have shown definite aptitude in diagnosis, should be possessed of a temperament that will assure the staff that he can adequately handle problems of an emergency character, understand and be tactful in all relations involving the medical practitioner outside the hospital walls and possess definite administrative qualifications.

The chief admitting officer should have medical assistants, and if the requirements for his position are high he should have attained to his headship of the unit by successive years of service through a period sufficiently long to familiarize him thoroughly with the personnel, practice and administrative routine of the hospital whose admissions he is to govern.

Among desirable attributes, the committee suggests that he be the product of a fellowship type of service, looking in its arrangement definitely towards a career for the men who pass through its training. Under all circumstances the medical admitting officer should be senior to an intern, his office tenure should be not less than two years and preferably more, and he should invariably have medical assistance. This medical assistance should be so arranged as to provide a staggered service, in order that at all times some experienced man may be in authority and on hand in the central admitting office personnel. It seems desirable also to have some member of the staff, probably the first year man, live in. The practice prevalent in many institutions, of permitting a junior intern to assume the major responsibility for the conduct of the receiving ward is open to serious criticism.

The important relation of the chief admitting officer to the medical staff seems to require recognition in that he should be an appointee, or at least that his appointment should be ratified by the medical staff.

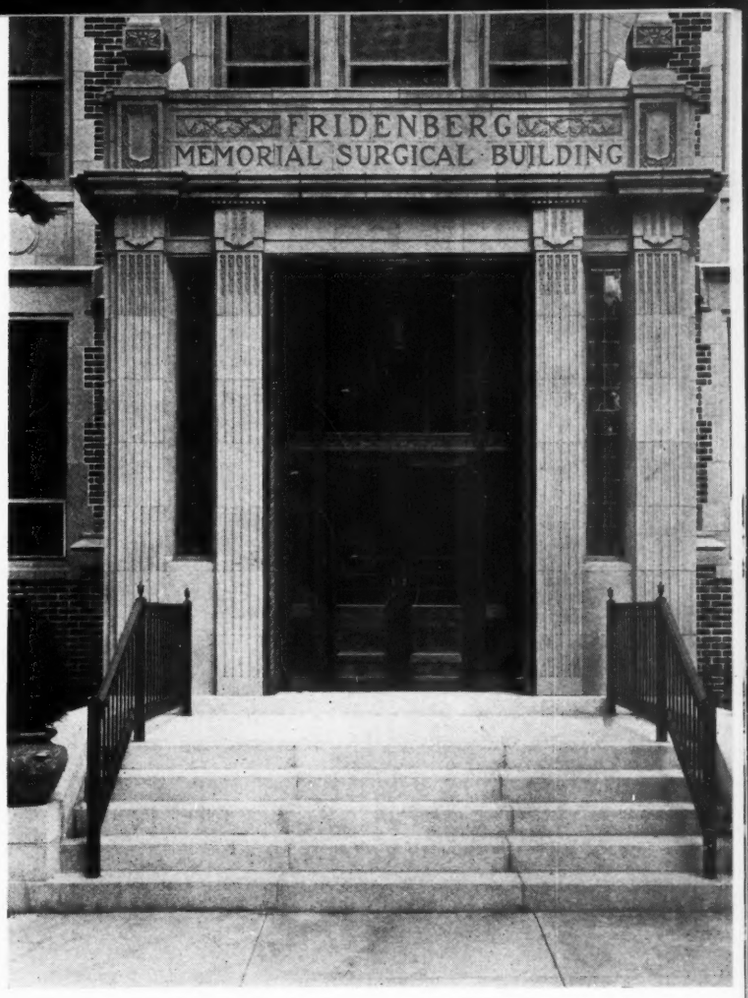
The maintenance of continuity of service of the highest type on the part of the central admitting office calls, the committee believes, for a twenty-four-hour duty type of organization. Some of the serious difficulties to which the admission problems of a hospital can give rise are connected with duty relief; with fluctuation in the capacity and responsibility of personnel; with dependence on relatively inexperienced persons substituted at night for the more experienced day personnel. While such problems will be influenced by the clientele and duty of the hospital to the community, an effort to maintain a high type of admitting service seems to be extremely worth while.

Who Should Count Laundry?

The time and effort necessary in the counting of linen are often out of proportion to the saving brought about. There are superintendents who contend that while some linen will be lost or stolen, the expense necessary to its protection by daily counting is greater than the loss thus sustained. Such an argument is generally conceded to be unsound because no one can take steps to prevent theft when no knowledge exists as to when and how valuable linens were lost.

Several superintendents who were interviewed recently agreed that the laundry should have the sole responsibility for safeguarding both clean and soiled linen both in transit and during the process of washing. The laundry representative should count linen in or adjacent to each department in the presence of a representative of the nursing department. This step, they believe, is the basis of any good exchange system. When this is not done arguments as to differences of quantities delivered and received are sure to arise. If the proper facilities are at hand for linen counting and an instructed personnel is available this work will not be too time consuming.

Head nurses need not always take part in this exchange of clean for soiled linen, the superintendents stated. Their time is often better spent elsewhere. But it is believed that floor supervisors should be held accountable for the proper transfer of the responsibility for this linen even though they are represented by a ward maid or some other nonprofessional person. To count laundry is to approach the problem of linen conservation in the only logical and efficient fashion, the consensus was



Sturdiness and simplicity feature the new surgical building at the Jewish Hospital, Philadelphia. Tapestry brick was used in its construction, with terra cotta door and window trimmings. The lower picture on the opposite page shows the ornamental bronze gates leading from the memorial hall to the children's ward.

Jewish Hospital Provides for Ward Surgical Patients

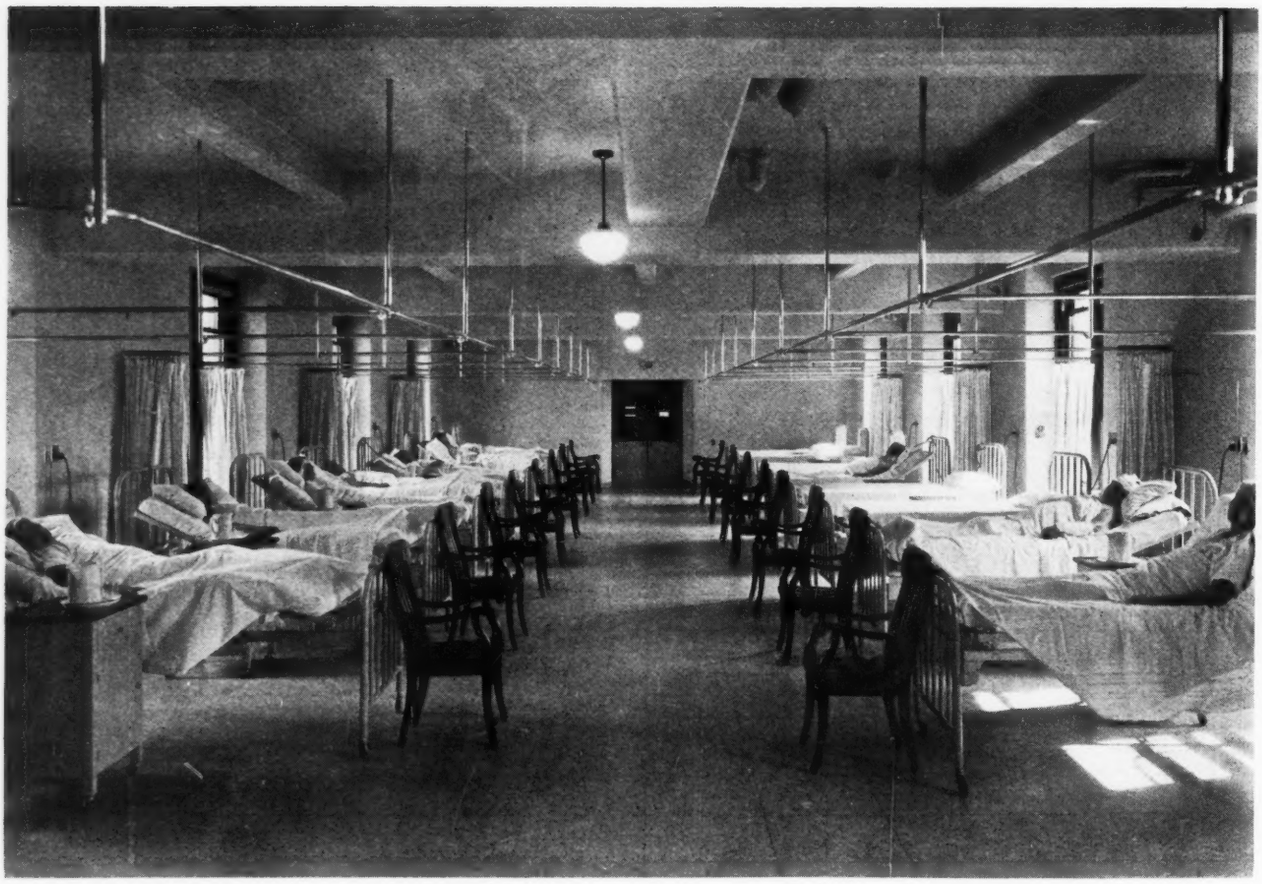
By JOSEPH C. DOANE, M.D. and HORACE W. CASTOR
Medical Director, Jewish Hospital, and Architect, Philadelphia

THE recently occupied surgical building of the Jewish Hospital, Philadelphia, known as the Fridenberg Memorial Surgical Building, was made possible through the gift of $400,000 in the will of the late Mone Samuel Fridenberg. It serves as an example of the fact that hospitals that were able to take advantage of low markets are today in possession of splendid buildings which were constructed at a very low cost.

This particular building has been put specifically at the service of ward surgical patients, there being no private facilities on any floor. In its construction simplicity and sturdiness were sought, yet there is a completeness which makes possible low upkeep without sacrificing service to patients.

The building is constructed on the detached plan, being connected with the main plant by a tunnel of sufficient width to permit free intercourse with the rest of the hospital. It is L-shaped, with the long dimension lying approximately east and west. Tapestry brick was employed, with terra cotta door and window trimmings. The building consists of five stories with basement and subbasement, and a roof garden which provides both outdoor and indoor facilities. The construction is of steel frame with concrete slab floors, the forms used being plywood, which made it unnecessary to plaster the ceiling. The floors are of terrazzo throughout except in the kitchens, where they are of quarry tile. The terrazzo floors are provided with expansion joints in 15-inch squares on a cushion of sand and paper, an arrangement which prevents expansion and contraction cracks in the terrazzo and also serves as a sound muffler. Ducts for future air conditioning were provided and specially designed noiseless, self-leveling elevators installed.

In studying future nursing possibilities, it was decided that it was far easier to nurse patients properly in larger ward units than in smaller subdivisions where patients are out of the observation of the nurse and so isolated that fewer nursing



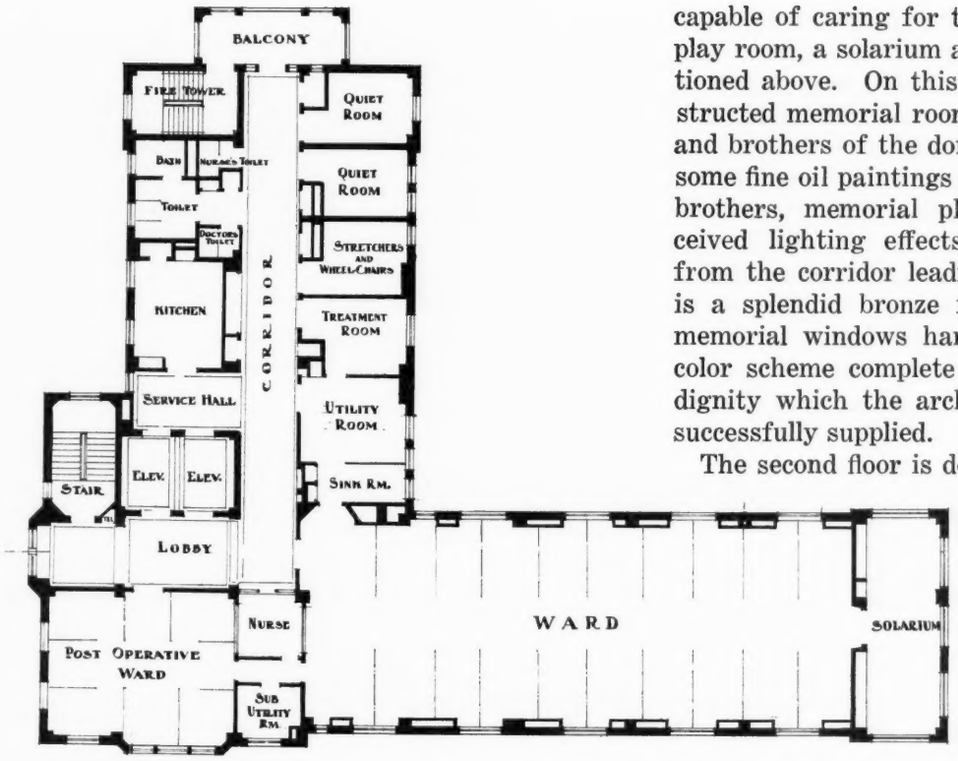
The standard ward, shown above, is 76 feet long and 32 feet wide, with a solarium extending the full width. The wards are cubicled, with nickeled support rods and serviceable curtains. Below is a view of the memorial hall, dedicated to the parents and brothers of the donor.

hours per day could be given them. The standard ward employed is one 76 feet long and 32 feet wide, with a solarium extending the full width and having a depth of 13 feet. These wards are cubicled with nickeled support rods and curtains.

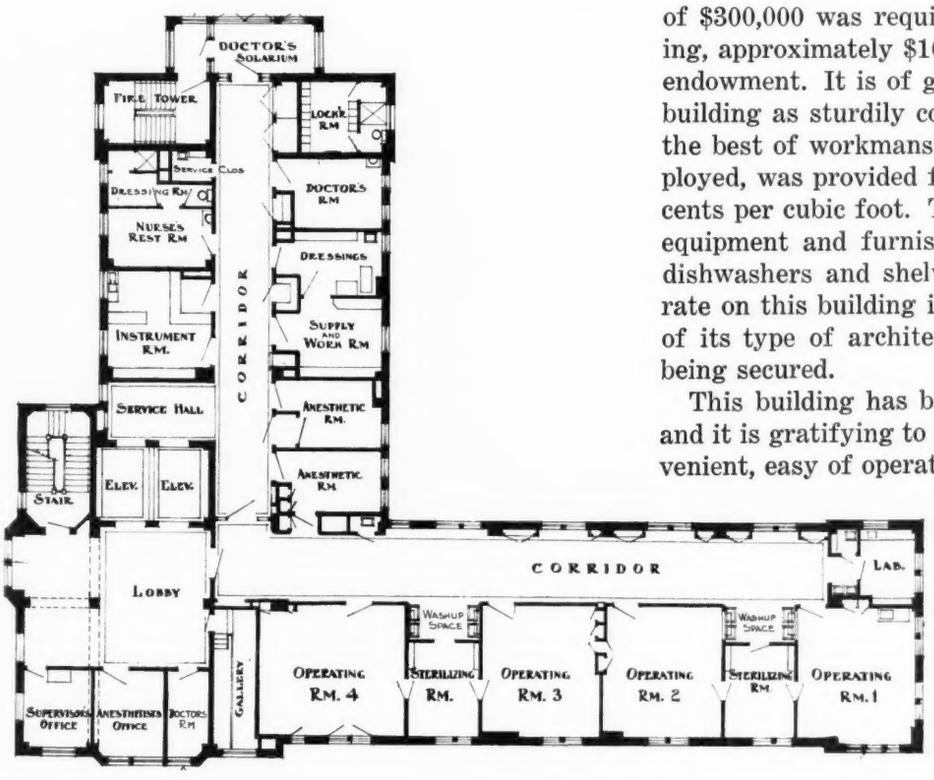
Nurses' Station Centrally Placed

In the short leg of the L, which roughly lies north and south, are to be found quiet rooms, treatment rooms, utility rooms, toilets and floor kitchens, with the elevators centrally placed. Facilities for the care of postoperative patients are provided in a ward capable of caring for six patients. The nurses' station is so placed that inspection of both the postoperative and the general ward as well as all corridors is possible by the nurse at all times. Full sterilization equipment has been provided on the third floor which is devoted to the treatment of women surgical patients. Sterile water is piped from this floor to the utility rooms of the second and first floors which lie immediately below. The equipment of these utility and treatment rooms is more or less standard, nonstaining metal being used throughout, and adequate shelving and warming closet space being provided. Linen chutes connect each floor with the linen sorting room in the subbasement.

The first floor consists of a children's ward



The second floor, a plan of which is shown above, is devoted to the treatment of men surgical patients. Dressing rooms, quiet rooms and sterilizing rooms are conveniently placed. The fourth floor plan is shown below. This floor is given over wholly to operating room space.



capable of caring for thirty-five children, with a play room, a solarium and the service rooms mentioned above. On this floor is a beautifully constructed memorial room dedicated to the parents and brothers of the donor. Here are to be found some fine oil paintings of the donor's parents and brothers, memorial plaques and carefully conceived lighting effects. Separating this room from the corridor leading to the children's ward is a splendid bronze railing, and stained glass memorial windows harmonizing with the entire color scheme complete this atmosphere of quiet dignity which the architect and the donor have successfully supplied.

The second floor is devoted to the treatment of men surgical patients. It houses approximately thirty patients. Dressing rooms, quiet rooms and sterilizing rooms are conveniently placed so that the nurses' time is conserved and yet these rooms are sufficiently removed from the ward proper to avoid annoyance to patients by necessary or unusual sounds. The third floor houses women surgical patients and its equipment is roughly identical with that of the floor beneath. The fourth floor is devoted wholly to operating room space. The fifth floor is the solarium or recreational floor.

From a practical standpoint, slightly in excess of $300,000 was required to construct this building, approximately $100,000 being set aside as an endowment. It is of great interest to note that a building as sturdily constructed as this, in which the best of workmanship and materials were employed, was provided for a final cost of forty-nine cents per cubic foot. This figure includes all fixed equipment and furnishings, including sterilizers, dishwashers and shelving. The lower insurance rate on this building is also somewhat suggestive of its type of architecture, a rate of four cents being secured.

This building has been in use for nine months and it is gratifying to note that it has proved convenient, easy of operation and low in maintenance cost. Moreover, at a time when community morale was low because of the existence of an economic depression, the construction of this building has offered much of spiritual benefit to the whole community.

What Others Are Doing

How One Hospital Paid for Its Awnings

The Marlboro County General Hospital, Bennettsville, S. C., needed some new awnings for the hospital and also a new stretcher. Promptly the active ladies' auxiliary of the institution stepped into the breach and devised a plan to raise the funds.

Envelopes like the one illustrated here were mailed to those who live in the vicinity and also to all the tourists who had recently been patients in the hospital on account of accidents or sudden illness. The response was splendid. From all parts of the country and from Canada came letters expressing appreciation of the service received in the hospital and enclosing in most cases $1. Some sent $5 and a few sent the price of an awning. The hospital acknowledged every contribution by sending a postcard view of the building, if possible placing an arrow pointing toward the room the patient had occupied.

A HALF-MILE OF PENNIES

The Marlboro County Hospital Auxiliary is undertaking a journey of half a mile of pennies—sixteen small pennies making a foot. Will you please put a foot—16 pennies—into this envelope and return to the collector?

TO_____

If you miss your foot, we may not complete our half mile. If you can, put in several feet. Thank You!

This is only one of many ways in which the ladies' auxiliary has given practical help. Mrs. Mary D. Gibson is the superintendent of the hospital.

Post Office Hands Over Uncalled-For Magazines

Uncalled-for magazines from the post office, recently made available by the federal postal authorities, help to entertain convalescent patients at the University of Iowa Hospitals.

Patients in the hospital for only a few days are the greatest users of these periodicals, as well as those to which the hospital library subscribes, states Zoe Wright, the librarian.

Convenient book racks attached to the head or the sides of the bed are recent additions to this hospital's library equipment. These are an aid to persons who must lie in a horizontal position and cannot hold the books.

Four university students on relief work assist the librarian, thus making it possible to keep the library in the general hospital open every day, except Wednesday mornings and Saturday afternoons when the librarian is in charge at the children's hospital library.

Conducts Drive for Better Requisitions

A campaign for better requisitions is under way at New England Sanitarium and Hospital, Stoneham, Mass., and already considerable time and money have been saved by it.

H. A. Munson, the purchasing agent, found that department heads were getting more and more lax in the matter of requisitioning supplies. He was determined also to stop the habit of rush orders and verbal orders. To these ends he wrote a broadside entitled "Wanted: Better Requisitions" and presented it in mimeographed form to heads of departments. In it he intimated that he was tired of using some judgment and a lot of guesswork to purchase what he thought was wanted. Because of inadequately worded requisitions, he declared, it was necessary for his office to be a mass of records, catalogues, trade directories and yearbooks, which he used chiefly for seeking the meanings of unintelligible requisitions.

The six rules he has laid down are simple but adequate.

RULES FOR WRITING REQUISITIONS

After carefully considering the need and the funds available, please observe the following rules:

1. Write the requisition FIRST! Don't give a verbal order and then expect the goods to arrive immediately. Write the requisition first!

2. After giving a verbal order for an emergency (seldom necessary), be sure the requisition follows immediately. Don't forget to write it.

3. See that you fill in the name of the department and that the requisition is dated and signed properly.

4. Be sure you give full details as to quantity, size, color and catalogue number.

5. Do not write across into the "Price" and "Amount" columns. These are reserved for figures.

6. Do not write on the last line. This is reserved for the total.

Social Agencies and Hospital Are Mutually Helpful

An interesting arrangement has been effected between Toledo Hospital, Toledo, Ohio, and the Children's Bureau in Toledo. The hospital provides a weekly clinic for the "clients" of this organization and offers hospitalization when necessary. In return, the head social worker of the bureau gives a college course in mental hygiene to the student nurses in the hospital.

Another of the community chest agencies in Toledo uses the hospital as health headquarters and a health teaching station. Furthermore the instructor in nursing practice in the hospital gives instruction to the Girl Scouts in home nursing care and in first aid.

George W. Wilson is superintendent of the hospital.

Courtesy Card Has Tangible and Intangible Value

A small thing, courtesy—yet often it contains great possibilities for good. This has been the experience of the Windham Community Memorial Hospital, Willimantic, Conn., with a little courtesy it is now offering.

Every clergyman and the head of every welfare and fraternal society in the seventeen townships served by the hospital has been provided with a copy of the "courtesy card" shown here.

Whenever a member of a church or fraternal organization is admitted to the hospital, the telephone operator notifies the clergyman or fraternal organization. Furthermore they are informed regarding the patient's condition from time to time. For their meetings the lodges are furnished with a report of all their members who are receiving care at the hospital.

This plan is welcome to the patients, the churches and the lodges. From a business angle it has been helpful to the hospital. "In one case alone the plan saved us $600 this year," writes William B. Sweeney, superintendent, "inasmuch as a lodge which got in touch with a patient through this card assumed responsibility for his bill."

COURTESY CARD

Windham Community Memorial Hospital

ALDEN B MILLS

The privilege of visiting our Patients is extended to you at any period of the Day. Please use the Staff Room, first floor adjoining Main Lobby, for conference, cloak room and toilet facilities. The Information clerk will endeavor to keep you informed of all the members of your congregation or organization, who are admitted to this Hospital.

William B Sweeney Superintendent

A COMMUNITY INSTITUTION

Three Views on Convalescent Care*

1. Social and Economic Aspects

By SAMUEL A. GOLDSMITH
Executive Director, Jewish Charities, Chicago

CONVALESCENT care deals with patients who have passed the critical stage of their illness, patients whose physical or mental state is either curable or, to use a tuberculosis term, can be held in an arrested condition, and patients who, with proper care, may regain health and be able to return to their occupations.

The aim of such care is to revitalize the patient, physically, socially and economically; to enable him to play his rôle, whatever that may be.

All kinds of physical conditions are found in convalescents. Not only are there postsurgical and postmedical conditions, but also the physically handicapped, the crippled, many of the so-called chronics and persons who are overfatigued or verging on what is popularly called a nervous or a physical breakdown. The prevention of serious physical deterioration or disease must also be considered.

The psychologic or psychoneurotic or psychiatric aspects of the treatment are important. Those who have had to do with convalescent work know as well as the average medical practitioner the mental shock that illness brings to the average human being, and how important therefore proper social case work guidance can be in bringing about a speedier recovery to reasonably good health and a speedier reintegration with the fabric of the individual's general social and economic life.

In this connection we have to pay particular attention to conditions affecting the revitalization of the individual as a social and economic being. We have to know a great deal about his home and a great deal about him as a person. Mere physical care, good food and rest have their effect. What probably has the greatest effect, however, is a thorough understanding of and case work approach to the individual patient.

Discussions of this problem have generally centered around the institutional phases of it. We have known the various types of institutional facilities — the convalescent beds that are included in the facilities of a general hospital, in order to free the more expensive hospital beds by filling the less expensive convalescent beds. We have discussed at length country convalescent homes as opposed to city convalescent homes, and country convalescent homes with respect to the fine effects of the country atmosphere and the effects of the regimen of country convalescent homes on neuropsychiatric patients. We have known, of course, that noninstitutional foster family homes or small nursing homes have been of value in certain types of cases. This has been discussed from the standpoint of savings in institutional costs. Administrators of convalescent homes and others used to tell us that from the standpoint of construction, equipment and per capita daily cost their figures should be approximately one-third or one-half of figures for general hospitals. It should, however, be obvious that this sort of saving, important as it is, does not begin to touch the essential problems of convalescent care which center around the revitalization of the individual.

Generally speaking, institutional convalescent care, whether in the country or in the city, can be organized only for a small minority of those who need it.

How Economy Is Achieved

Undoubtedly, convalescent care given through the various means that have been cited tends to save in the construction of hospital beds and in a better utilization of hospital beds. A general convalescent program that uses not only institutional facilities but all methods of care will not only obviate the need for more acute hospital beds but may help us to meet the unsolved problem of the best utilization of the beds in institutions for mental disease.

We have not to the fullest extent utilized the normal way of meeting the situation. Convalescent care is an involved procedure in which social workers and physicians need to cooperate. The most natural procedure would be, insofar as the dependent or semidependent population is concerned, to have an arrangement whereby socially minded physicians would be employed on a full-

*Conclusions reached at a recent symposium held by the Chicago Council of Social Agencies.

time basis, together with social workers, in an endeavor to bring about a reasonably good adjustment of the convalescent patient within the normal surroundings in which he lives.

The teaming of the social worker and the physician in this process, both employed full time, either by organizations dealing with convalescent care or by the usual case work agencies, would make possible physical care and supervision. At the same time, it would make possible a more reasonable understanding of the need for convalescent institutional facilities and therefore a better utilization of whatever facilities have been established. The physician has not been fully utilized in this field any more than he has been in the field of treating and helping the chronic sick.

Of course, we are dealing with many dependent persons, for whom we wish to do everything possible in the way of reconstruction, socially, economically and medically. Experiments we are conducting with families presenting chronic physical difficulties lead me to say that it would be wise to extend such experiments, in which physician and social worker are joined, to the field of convalescent care. This would provide a natural and easy way of first dealing with the problem within the home when that is at all possible.

Since administrators of convalescent homes seem to agree that the best thing to do is to make the institutional facilities seem as noncustodial and noninstitutional as possible, and to put the patient on his own as much as possible, in order to frustrate the development of neuroses, it might be just as well to go a step further, namely, to do the job within the family home and through the temporary ministrations of physicians and as much of the ministrations of social workers as may be required, but absolutely no more. We might thus be able to reach a great many more people than we can now with our limited institutional facilities, and we might reach them in a better fashion.

Why Some Refuse Convalescent Care

The present general economic condition has brought to our minds forcefully that we must be as much concerned with the capacity of the individual to obtain various types of physical care as with the methods by which the care is given.

Colonel Cunningham, who conducts the Astley-Ainslie Institution in Edinburgh, Dr. Frederic Brush, who conducts the Burke Foundation in White Plains, N. Y., and many other skilled administrators in the field of convalescent care, are convinced that the average employed person has refused to accept convalescent care, even when needed, because first, he felt that neither he nor his family could afford to lose income during the period of convalescence, and, second, he was fearful of losing his job. These factors are undoubtedly more important today than they were before the depresison. Jobs are scarcer and more precious. Hence, it is probably true that many who most need convalescent care are not able to afford the time or the money that care implies.

If we are really serious about giving convalescent care to the people at large who need it and not to a selected few who are either desperately poor or reasonably well-to-do, there is only one answer. That answer lies in health insurance which offers a reasonable way by which convalescent care can be definitely paid for, and by which employers will understand that convalescent care as well as acute medical care needs to be provided on behalf of workers, so that they may regain their health over a reasonable period of time without sacrificing their economic foothold.

2. What Chicago Needs

By C. RUFUS ROREM
Associate Director, Medical Services, Julius Rosenwald Fund, Chicago

CHICAGO'S facilities for convalescent care are entirely inadequate, in fact they constitute not more than 15 per cent of the capacity which could be utilized to advantage. This shortage of convalescent care facilities exists side by side with a large number of unoccupied beds in nongovernmental general hospitals.

At least one-third of the surgical patients in Chicago's general hospitals could be adequately served in properly managed and equipped institutions for convalescent care. The service would be less expensive than for acute cases.

Both physicians and hospital administrators have an interest in the problem of convalescent care. Physicians have too often failed to recognize the advantage of moving a patient from expensive hospital accommodations to equally desirable accommodations in a private home or in a hospital exclusively for convalescent patients. On the other hand, they frequently are obstructed by inability to find suitable facilities outside the hospital. Hospital administrators cannot be blamed for a lack of interest in convalescent facilities, if patients continue to occupy the accommodations for acutely ill cases and pay the regular hospital rates. But for patients unable to pay regular hospital rates hospital administrators should consider

establishing special wards, wings or pavilions for convalescent cases, such facilities to be available at rates such as $1.50 to $2 a day.

The foster home has been utilized for convalescent care in Chicago, although on a limited scale. Where the foster home care is coordinated with a visiting nurse or hourly nurse service, it offers new and undreamed of possibilities for the public health. The visiting nurse is a specialist in the care of convalescent cases, once the demand for the services of a physician has passed.

Doctors and Social Workers Must Cooperate

The social and economic aspects of convalescent care are not different from the care of patients during the acute stage. From the social point of view, it is necessary that the physicians and social workers combine in attempting to deal with the problem, particularly among persons with limited incomes. Adequate care during convalescence helps to prevent the return of an illness, and also hastens the restoration of the patient's capacity to participate in economic activity.

As to financial support, convalescent care must utilize the same sources of funds as other medical services. The well-to-do may continue to pay for such services through private fees, either in hospitals or at home; they present no special problem. The unemployed and otherwise dependent group must rely upon government taxation or private philanthropy, which has all but ignored the special economic problems arising during convalescence. The majority of employed persons find the economic burden of convalescence as heavy as that for care during the acute stage. Money spent during the beginning of treatment often compels a patient to ask for help during the period of recovery. If convalescent care is to be provided for the majority of the public, it must be included in their family budgets. This requires application of the principle of health insurance.

The following lines of action appear to be desirable in providing better medical service in Chicago during periods of convalescence:

1. The establishment of branches of the Cook County Hospital in outlying communities, to which patients can be removed for supervision during convalescence. This would improve the environmental conditions affecting recovery, lower the per capita cost of the care of patients, and would release facilities in Cook County Hospital for services during the acute stages of illness. Cook County Hospital is crowded with numbers of long-stay cases which might well be cared for in convalescent homes, or even in the patients' homes if arrangements were made for supervision or limited professional care during recovery.

2. The establishment of branches of the nongovernmental general hospitals for convalescents.

3. The adaptation of unused facilities in nongovernmental general hospitals for the care of convalescent cases, at rates sufficient to cover the out-of-pocket expenses for salaries and supplies.

4. The development of supervised foster home service for convalescent cases, coordinated with the present visiting nurse services in the city.

5. Special emphasis on the professional and economic advantages of visiting nurses during convalescence in the patient's home.

6. The development of the case work concept in the care of the sick, by which doctors, nurses and social workers combine their efforts toward complete and rapid recovery at the lowest possible cost.

7. Systematic financial support of the care of the sick, through private fees, taxation, philanthropy and systematic budgeting by employed individuals.

3. What Chicago Has

By ALEXANDER ROPCHAN

Executive Secretary, Health Division, Council of Social Agencies of Chicago

CONVALESCENT care is an indispensable complement to hospital treatment. At the present time when many patients discharged from hospitals return to homes where they cannot obtain the type of care necessary for full and rapid recovery, it is especially important that adequate convalescent facilities be provided.

Seven homes, all established by private philanthropy, constituted Chicago's convalescent facilities in 1934.

The seven institutions reported a potential capacity of 522 beds, but only 290 beds were available for the use of patients throughout the year. There were also sixteen beds available only during the four summer months. Funds were insufficient to make use of the remaining beds. New York with twice the population has ten times as many available beds for convalescence.

Various estimates of adequate provision for convalescent care have been made. One estimate is that under normal economic conditions convalescent beds should be provided equivalent to 12 to 15 per cent of the total hospital bed capacity. Chicago, on this basis, requires between 1,800 and 2,250 beds. According to another estimate, 12 per cent of all hospital patients require convalescent care. On this basis Chicago, with 275,000 patients

admitted to hospitals yearly, requires 2,000 convalescent beds for 33,000 patients, assuming an average convalescent stay of three weeks.

These estimates are merely suggestive. The actual demand for convalescent facilities will depend upon economic and housing conditions, upon appreciation by medical staffs and hospital administrators of the advantages of convalescent care for their patients, upon the interest displayed by social agencies, upon the accessibility of the convalescent home, and upon its admitting and operating policies and procedures. But by any reasonable estimate Chicago had available not more than one-seventh of the beds required for convalescent care.

TABLE I—CONVALESCENT FACILITIES FOR CHICAGO
(Exclusive of Fresh Air or Vacation Facilities and Exclusive of Proprietary Institutions)

Institution	*Available Beds 1935*				*Total Bed Capacity**
	Total	*Children*	*Men*	*Women*	
Chicago Home for Convalescent Women and Children	38	38	0	0	56
Country Home for Convalescent Children	100	100	0	0	120
Grove House	37	16	0	21	45
Jewish Home for Convalescents	10	3	7	0	30
LaRabida Jackson Park Sanitarium	30	30	0	0	150
Martha Washington Home	38	38	0	0	39
Resthaven	40	0	8	32	82
Total	293	225	15	53	522

*The figures on total bed capacity apply to 1934. The Jewish Home for Convalescents was recently opened, which explains why it is not fully available. All the items have failed to utilize their full capacity because of lack of funds.

The available beds were not synchronized with needs. Children were most adequately provided for with 225 beds available to them. There were fifty-three beds for women and seventeen beds for men. Orthopedic and cardiac conditions in children were more liberally provided for than were other types of cases.

TABLE II—VOLUME OF SERVICE AND COST OF CARE OF FIVE CONVALESCENT HOMES, 1934

Home	*Patient Days' Care*	*Operating Expenses*	*Cost per Patient Day*
A	7,748	$ 8,931	$1.15
B	10,873	15,200	1.40
C	32,048	59,000	1.84
D	13,330	22,000	1.65
E	14,713	24,049	1.63
Total	78,712	$129,180	Average $1.63

Even the superficial application of accepted standards for convalescent homes indicated that Chicago's homes generally did not measure up. Only two of the homes were well located. Generally patients did not have the advantages of occupational therapy — recognized as having great and permanent therapeutic value in convalescent care. There was room for improvement in educational and recreational programs, especially important in institutions caring for children. Trained dietitians were lacking in some cases. Admitting policies were often intended to serve the convenience of a particular institution rather than to meet community needs. In most cases the homes occupied old buildings originally used for residence or other purposes.

There was no lack of demand for the available convalescent beds. In 1934 an average of 249 patients were cared for in 279 available beds in six homes. As an average, 89 per cent of the beds were occupied throughout the year. This is about as high as is practical after making reasonable allowance for losses in time due to renovations, temporary shutdowns and intervals between the discharge of old and admission of new patients. The seven homes took care of about 1,100 patients during the year.

The costs of caring for patients in six homes varied from $1.15 to $1.84 per patient per day, the average cost being $1.63 per patient per day. This compares with a cost of from $5 to $7 per day per patient in most charity hospitals. The seven convalescent homes spent less than $150,000 for operating expenses during 1934.

Chicago has experimented with the placement in foster homes of children requiring convalescent care. According to a study made by the Illinois chapter of the American Association of Medical Social Workers, forty such placements were made for eight hospitals and dispensaries during the last eight months of 1934. Children's agencies cooperated with hospitals and clinics in this program, the former selecting the homes and generally financing the cost of this care.

Physical Therapy Personnel

The most important requirement for a physical therapy department is properly trained personnel with a physician in charge, according to Dr. John S. Coulter, Chicago, writing in the thirteenth edition of The HOSPITAL YEAR-BOOK. "Equipment of the department is of less importance than the personnel. A resourceful director and a competent technician can start a physical therapy department with entirely homemade equipment that costs little. Hospital funds are usually limited and it is often advisable to start the department with little equipment and buy more as needed."

Doctor Coulter's article contains a check list on planning the department and another on its equipment.

What Is Your Choice?

In July The Modern Hospital *published an editorial setting forth the need for an accurate terminology for all classes of hospitals, but especially for the nonprofit, nongovernment class, and requesting suggestions from its readers. This article presents the gist of the replies*

A NAME, of course, is only a tag. But every word has shades, overtones and connections that mean much to all who use or hear it. Age-old beliefs, feelings and prejudices begin immediately to tug and pull and, in some cases, distort, the mental images a word suggests.

Whether hospitals maintained by various groups without thought of profit, that is, under eleemosynary charters, and without substantial assistance or control from government agencies should be called *voluntary, public, community, charitable, philanthropic, independent, nonprofit* or *nongovernmental,* is more than an academic question. The right decision on this question will unconsciously but definitely influence the attitude of the public toward these institutions.

The requirements of a name are two: first, it should be technically correct, agreeing with sound dictionary definitions; second, it should carry the right connotations to ordinarily well informed people and should be easy and natural to use.

To clear the ground here are definitions of the first six terms as given by Webster:

Voluntary—of or pertaining to voluntarism; as in a voluntary church, in distinction from an established or state church. *Voluntarism*—Voluntary principle; the system of supporting or doing anything by voluntary action; specif.: a. In education, the system of voluntary schools or of supporting schools by voluntary subscriptions.

Public—1. Of or pertaining to the people; relating to, or affecting, a nation, state, or community at large; opposed to private. 2. Open to common or general use.

Community—1. A body of people having common organization or interests, or living in the same place under the same laws and regulations. 2. Society at large; a commonwealth or state; a body politic; the public, or people in general.

Charitable—2. Liberal in benefactions to the poor; giving freely; generous; beneficient. 3. Of, or pertaining to, or springing from charity; relating to almsgiving; eleemosynary.

Philanthropy—Love to mankind; benevolence toward the human race; universal good will; desire and readiness to do good to all men.

Philanthropy is distinguished from charity and almsgiving. The first is the spirit of active good will towards one's fellow men, especially as shown in efforts to promote their welfare. Charity is benevolence, especially as manifested in provision, whether public or private, for the relief of the poor. Almsgiving is applied only to material relief and not to the spirit that prompts it. Philanthropy deals with large masses and more frequently prevents than allays calamity.

Independent—1. Free; not subject to control by others; not relying on others. 3. Separate; exclusive. 4. Not dependent for support or supplies; having a competency. 5. Not subject to bias or influence; not obsequious. 7. Declining assistance from others through proper pride.

A Question of Good Judgment

There is, obviously, some justification in using any one of these terms. The question, therefore, largely resolves itself into one of judgment as to the term with the best associations.

Voluntary is the preferred term in the judgment of Dr. W. L. Babcock, Grace Hospital, Detroit. Doctor Babcock thinks *private* objectionable as a term to distinguish the nonprofit from the publicly supported hospital, because it "connotes personal or private ownership."

Dr. Alan Gregg, director of medical sciences, Rockefeller Foundation, casts his vote for *voluntary* in the following words:

"It would seem better to follow the usage common in England and consider *voluntary* as meaning a nongovernmental, nonprofit hospital. Though the word in its literal interpretation is a bit vague, such an objection could hardly stand in the way of its more generalized adoption to indicate a special type of institution."

Another ballot for *voluntary* comes from Dr. C. W. Munger, Grasslands Hospital, Valhalla, N. Y. He would qualify it when necessary by such terms as *private, fraternal, denominational.* Doctor Munger goes on, "I have some leaning toward the use of the term *nonprofit* for its brevity and understandability. It seems to me that the word *public* with suitable adjectives such as *county, state, federal,* describes that type of hospital, and that the word *proprietary* describes the remaining type."

Because the term *community* is sometimes part of the corporate name of *voluntary* hospitals and in other cases applies to municipally owned and operated hospitals, Dr. A. C. Bachmeyer, University of Chicago, thinks it indefinite. He says:

"The term *voluntary* does not fully cover the situation, but would it not be better to foster the use of this term to designate hospitals created by citizen groups or church, fraternal and other similar groups who are under no legal compulsion to act, and are not organized for profit, than to invent some new and equally indefinite designation?"

"Voluntary" Pulls Many Votes

From Dr. Hugh Cabot, Mayo Clinic, Rochester, Minn., comes the following: "My opinion is that as people get a little more accustomed to the use of *voluntary,* this will on the whole be best. I despair of introducing any new term where there are already so many in the field. The essential fact which should be kept before the public is that these hospitals depend for their support to a considerable extent upon *voluntary* contributions. If, with the present trend of political thinking, the sources of such contributions are systematically dried up, we shall not need to bother about the term. If, as I hope, this is not going to be the case, then the accentuation of the voluntary aspect seems to me important."

The secretary of the department of hospital service of the Canadian Medical Association, Dr. G. Harvey Agnew, likens the present situation to the confusion of tongues at Babel. He, too, would confine the use of the word *private* to privately owned institutions, special and general, and call the other general hospitals accepting patients on a non-pay or part-pay basis *public* hospitals — *public voluntary* if operated by nonprofit organizations, or religious or fraternal bodies, *public governmental* if controlled by state or local governmental agencies.

He continues, "The term *community* hospital would seem most applicable to the voluntary hospital of a nondenominational nature supported by all groups in the community, but one sees difficulty in its use because of its application also to the *community owned* hospital. I strongly favor retaining the term *voluntary.*"

Federal hospitals for war veterans, quarantine, state mental hospitals, and communicable disease hospitals, he would classify as *special governmental.*

Voluntary has another proponent in Dr. Lewellys F. Barker, Baltimore, who says, "It seems to me that we cannot do better at present time than to retain the term *voluntary hospital* for the nongovernmental hospital. If an additional adjective is to be used one could speak of *voluntary nonprofit* hospitals when they are such."

Dr. C.-E. A. Winslow, Yale University School of Medicine, contributes the following, "I am inclined to agree that *voluntary* is at present the only available word. Since a word is merely a tag, there is not much use in disputing as to the meaning it ought to carry. We have the English practice behind us, and I think if we continue to apply the word *voluntary* to nongovernmental, nonprofit institutions, everyone will understand us."

Brief and to the point are the words of Allen T. Burns, executive vice-president, Community Chests & Councils, Inc., New York City:

"We are glad to commend the use of the term *voluntary hospital* to designate the hospital not operated for profit and yet not under government administration. The term comes as near to being distinctive as any we have seen."

A Lay Opinion

Because it comes from one of the lay public in whose interest this search was largely instigated, the remarks of Eleanor Rowland Wembridge, referee of the Juvenile Court of Cuyahoga County, Ohio, are of particular interest. They are as follows:

"I cannot see any objection to the term *community* hospital. I have never even heard *voluntary* or *nongovernmental* applied to a hospital. To me they seem clumsy and do not explain the situation any better than *community,* which has been in general use wherever I have lived."

The striking suggestion that we scrap the very word "hospital" and make a fresh start comes from Dr. E. M. Bluestone, Montefiore Hospital for Chronic Diseases in New York City. However, on the assumption that this word, "imperfect as describing an institution for the care of the sick," is to be retained, he proposes *philanthropic* to identify such institutions when they are organized not for profit and are not under governmental control. Here is his argument:

"A *philanthropic* hospital would normally be defined as a hospital which depends on voluntary contributions for its existence. It could not be

confused with the so-called *public* hospital, which lacks such a basis, or with the proprietary hospital, which has no element of philanthropy in it."

Dr. L. V. Ragsdale, assistant director, Massachusetts General Hospital, Boston, thinks it a mistake to abandon the word *charitable,* saying that many patients paying a fifty-cent admission fee in the out-patient department or $3 a day for care in the ward demand the services and privileges of a pay patient. When they understand that their fees do not fully reimburse the hospital for their care and that the physicians make no charge at all for their services, their attitude changes.

To Accept Charity Is No Disgrace

Dr. Nathaniel W. Faxon, Massachusetts General, who sends in Doctor Ragsdale's comment, goes on to say, "We have been taught by students of sociology that telling a person he is a recipient of charity degrades him. . . . While I believe it wise not to speak unnecessarily of disagreeable matters, I do not share the feeling that it is a disgrace to accept medical and hospital charity when acceptance is justified. Nor do I believe it harmful to the self-esteem of the recipient to tell him he is accepting it. I believe that far more damage is done by leading people to believe they are paying their way when they are not. . . ."

Doctor Faxon's own first reactions to the problem are also worthy of consideration:

"*Voluntary* has little to recommend it except the fact that it is an established custom in England and that it does not conflict with any other terms.

"*Community* seems undesirable because all hospitals are essentially community institutions.

"*Nongovernmental,* although cumbersome, nevertheless to my mind comes nearer to expressing the type of hospital and classifying it than any other term. Objection has been made that it does not distinguish between the philanthropic or charitable incorporated institution and that which is incorporated for private gain.

"*Private* is ambiguous because it may refer to classification of patients or type of corporation.

"The choice seems to me to lie either in such terms as *nongovernmental* or *nonprofit,* or in some combination of these."

"I agree with you that the terms with which we classify hospitals are not as clear as they should be even to physicians, and are much more confusing to laymen," begins Dr. Hugh S. Cumming, Surgeon General of the U. S. Public Health Service. He goes on to recommend, as does Dr. William D. Cutter, council on medical education and hospitals, American Medical Association, the A. M. A. classification into (a) *government,* (b) *nonprofit,* and (c) *proprietary* as suitable designations for these three divisions; the first to include all hospitals supported by tax funds, the second those maintained by churches, fraternal orders, and other corporations operating under eleemosynary charters, and the third those under individual, partnership and corporation ownership, with no restriction as to profit.

"Words and phrases have a far greater significance than we usually impute to them," writes Perry Addleman, public relations counsel and consulting director of the Chicago Hospital Council. "If we study the philology of the words *charitable, philanthropic* and *voluntary* we find that by now they all suggest to the average mind a series of overlapping ideas. Many of these suggestions are not, I believe, good for the hospital. They connote good will to fellow man, goodness of heart, desire to help one's fellows and even social consciousness. But they also connote spontaneity, emotional impulse, and good deeds done on the spur of the moment and forgotten. They have no adequate implication of fixed and continuing responsibility. And they definitely oppose in their suggestion the thought of plan, method, system, rationality and consequently studied effectiveness.

"The use of these words, therefore, has detracted from rigorous thought processes in the development of hospitals and eventually from good management. *Charitable, philanthropic* and especially *voluntary* lack any compulsion toward the idea of fixed and continuing responsibility to the public. This is all too apparent in the writings and addresses of many hospital people who still seem to feel that they should be especially honored by the public because of their service. They forget that they are public employees.

"It seems to me that *nongovernmental* and *nonprofit* might be eliminated because they are negative. That leaves *public, community* and *independent.* And could we all agree to use one name so that it might be given exclusive currency and thus have its meaning properly filled in on a rational foundation, I prefer them in that order."

Let the A. H. A. Cast Deciding Vote

To sum up: *voluntary, independent, philanthropic* or *charitable, nonprofit, public* are suggested for the one type of hospital; *public* or *governmental* for the second, and *private* or *proprietary* for the third. Merely on the basis of counting noses, *voluntary, governmental* and *proprietary* were the three most often favored.

It would be fortunate if the American Hospital Association at the coming meeting would, either through its board of trustees or its council on community relations, give consideration to this question and recommend a term for general use.

Huggins Goes Over the Top

THERE was rejoicing in Wolfeboro, N. H., this summer. Its hospital, Huggins, had won the official approval of the American College of Surgeons. Proof of this fact was posted prominently on the bulletin board at the front entrance — a letter signed by Doctor MacEachern told the story. Further, had it not been described, unofficially to be sure, as a Utopia in rural hospitalization?

The news spread fast. Citizens of the town rested from their labors in catering to the summer tourist trade to express their satisfaction. Not that they needed any reassurance of the services of their hospital. For almost thirty years it had administered to their needs efficiently. It was gratifying, nevertheless, to know that this little building wherein centered so many of the mysteries of life and which during the years had become a part of the community, had passed the same test as the country's largest medical centers.

Within the hospital the same feeling of gratification was omnipresent. Each and every member of the organization from the head of the staff to the humblest worker regarded it with respect — that sheet of paper posted on the board — and experienced new pride in his participation in its affairs. Even the rush of work during one hot summer's afternoon induced by an emergency operation for a ruptured appendix and the fact that every nook and corner of the building was

The first step toward modern hospitalization at Wolfeboro, N. H., was this cottage, located on a tract of eleven acres, purchased for $18,000. It opened in January, 1908, with a capacity of twelve beds, which in emergency could be expanded to sixteen. It was not long before these facilities proved inadequate.

By RAYMOND P. SLOAN
Associate Editor, The MODERN HOSPITAL

crammed full failed to dim the enthusiasm.

There is justification in the esteem with which Wolfeboro regards its hospital. In these times when melting deficits threaten proprietary institutions the country over, it is significant that a small rural hospital with an enviable reputation for its surgical and medical work, which also serves its community as a health center, can be operated not only so as to make ends meet but to show a small yearly profit.

The picture as it stands today is briefly this. Huggins is a thirty-five-bed hospital with seven bassinets, located in the southern part of Carroll County, New Hampshire, in the heart of the lake region. Almost at its very doors lies Crescent Lake which opens into Lake Wentworth. Within a stone's throw, too, is Lake Winnepesaukee, of even greater renown. The town itself has a population of about 2,500, but that territory which the hospital serves embraces most of the southern part of the county comprising a permanent population of about 7,000 which in summer reaches nearly 10,000.

One or two industries engage the interests of a very small percentage of the population of Wolfeboro. A shoe factory, for example, is responsible for some industrial activity, which is abetted to a degree by the presence of a foundry. In one occupation, however, almost everyone shares alike — the summer tourist. Pretentious hotels on the lake front attest to this as well as numerous tourist homes on the side streets. Everywhere are signs designed to whet the appetites of insatiable travelers for anything they might desire from genuine antiques down to homemade fudge.

Yearly Occupancy From 700 to 900

The hospital administers to between 700 and 900 patients a year with births reaching a total of about 100. Last year the records showed 100 births, 500 surgical cases with 400 operations and 300 medical cases. Ward rates are $3 daily; semi-private accommodations are $4 and private rooms range from $5 to $10. A charge of $3 is made to ward patients for the use of the delivery room and $5 to private patients.

To provide for this number of patients and to operate the hospital plant efficiently requires a staff of about twenty. Sometimes this is increased, as for example, during the summer months when the occupancy rate is invariably higher. The nursing group varies, but generally it comprises eight, all of them graduates.

Two or three bedside maids are also provided. In addition to the superintendent, Frances B. Puffer, there is an assistant superintendent, technician, housekeeper, cook, janitor and three or four maids.

During the past year and a half arrangements were completed with Tufts University in Boston whereby one resident intern is supplied from the senior medical class. The term is for two months, but the man serving the last two months of the college year was kept on during the summer.

To complete this sketchy picture, it should be explained that the hospital complete with property and equipment represents a value of about $70,000. The nurses' home which is across the street is valued at $10,000.

Bearing these facts in mind, it is interesting to scan the statement of income and disbursements for the year ended September 1, 1934. The total

was $41,941.95. There was, for example, a balance on hand of $3,535.60 as of September 1, 1933. Collections totaled $24,187.98. Income from the hospital's endowment reached $12,167.37. To these were added miscellaneous income of $316 and income from contributions to the amount of $1,735. The disbursement side shows a pay roll of $12,-809.41. Salaries of officers are listed at $500. Some interesting items are food supplies, $5,-655.75; medical supplies, $3,210.62; miscellaneous supplies, $398.35; fuel, $1,007.91; repairs, $1,-220.81; water, $119.25; telephone, $225.82; insurance and bonds, $770.55; laundry, $3,171.98; electricity, $490.32; nurses' home expenses, $835.21; x-ray, $533.53; anesthetics, $704.50, and miscellaneous expenses, $2,165.20. Charges made to special accounts were listed at $1,143.10; investments reserve fund was figured at $1,500, and a balance as of September 1, 1934, amounted to $5,479.14.

Charges to special accounts are explained by the fact that certain individuals in Wolfeboro, and adjacent towns as well as the townships themselves, have established hospital funds for specific purposes. One of these, for example, provides for the care of worthy girls who may require hospitalization. The towns of Tuftonboro and Wolfeboro, among others, have set up funds for charity cases.

The results attained, however, have been made possible only by the closest supervision on the part of the superintendent and her staff as well as the executive committee, coupled with the wholehearted interest which everyone shows in the hospital and its work. It is a community project in the truest sense of the word, run efficiently within, governed wisely without.

Nearly thirty years of striving has resulted in a miniature health center located in Wolfeboro, N. H. Not only has this thirty-five-bed hospital established high standards, but the end of each year finds it with a small balance to its credit. It is well worth a Little Journey to Wolfeboro to discover precisely how this is accomplished

The fact that the building is one story, with practically everything on the one floor, facilitates procedure considerably. It is long and low with a wing at either end. The front section of one of these wings comprises a completely equipped and modern operating suite, the gift of an interested friend. Adjoining it is the maternity department, really a high, light, airy sun room in which five beds have been placed. At the other end of the building accommodations are provided for the use of men patients. Then there are two wards of four beds each, one ward of two beds, affording what amounts to semiprivate accommodations, and twelve private rooms. On the basement floor are the kitchen, dining room, living quarters for the intern, the laboratory, the library and maids' rooms.

Despite this practical and economical floor plan, the high quality of service rendered by a group of some twenty individuals represents constant activity and willingness on the part of each to help in emergency. In the ordinary routine, the superintendent arranges the menus and supervises special diets. Her assistant serves as supervisor of nurses and is also in charge of the operating room. The housekeeper assists in the kitchen. Everyone fills in as required — such is small hospital life.

Then come emergencies, as emergencies have a habit of doing. It is toward the close of a warm July afternoon. In the absence of Miss Puffer, Florence Gallant, her assistant, is in charge. Every bed is occupied and an emergency operation is in progress. Miss Gallant cannot be seen. She is in the operating room. Pending her arrival Miss Boyd, the technician, conducts the visitor about and stops to chat for a few minutes in the library, a comfortable room in the basement, originally intended as a garage, but now filled with antique furniture, shelves lined with books, a cabinet containing old surgical instruments and numerous curios to which the hospital has fallen heir.

In the course of telling an interesting incident involving an old scalpel, she is summoned — an emergency. She excuses herself, inviting the visitor to wait upstairs in the business office. En route, a glance about the hospital's own laboratory reveals it completely equipped with basal metabolism apparatus and electrocardiograph.

Soon Miss Gallant enters. No sooner is she seated at her desk than the telephone rings. A respite of a few brief minutes and she talks about the hospital and its many services, the interest shown in it by the people of the community, yet the difficulty at times in making collections, particularly in maternity work. At this particular moment, she is called upon to make change for a departing patient who would pay his bill in cash.

"You see," she explains, dropping a roll of bills into the cash drawer, "we all must do a bit of everything, particularly during our busy season."

Such is hospital life as it is encountered in Wolfeboro today.

Suddenly the scene shifts. In its place is a doctor's office located two blocks from the main thoroughfare in the same town. A comfortable, cozy place on a dismal winter's afternoon back in 1907.

Today Huggins Hospital is a thoroughly modern institution with a bed capacity of thirty-five and seven bassinets. Last year its records revealed 100 births, 500 surgical cases with 400 operations and 300 medical cases. It comprises a veritable health center for the entire community.

A sharp wind from the lake shakes the window panes threateningly. Completely unmindful of its vengeful warnings are the two men seated at the desk, so engrossed are they in discussing the desirability of a hospital for Wolfeboro.

The need was great, both Dr. F. E. Clow and Dr. C. B. Cotton agreed. Each knew the limitations imposed by long treks into remote sections to deliver a woman or to perform operations on a hastily improvised pine table by the light of a flickering kerosene lamp. The question under consideration was one of establishing hospital headquarters in some house in the neighborhood under the supervision of a nurse who was married and lived in the town.

The possibilities of such a plan were brought to the attention of others, among them, the Huggins family. John Huggins, whose name the hospital bears, was a Wolfeboro boy who went to New York and "made good." His sister had married James Martin, and it was Martin to whom the two doctors went for support. At the same time the interest of other doctors was aroused and help solicited from other influential citizens.

Within the next few months a sum of $8,000 was raised in addition to a gift of $10,000 from Mr. Martin. With this a small house was purchased standing on eleven acres of ground. Its capacity was twelve beds which in emergency could be expanded to sixteen. This building was dedicated December 31, 1907, and the first patient admitted on January 2, 1908.

It was a start, if but a meager start. There were few voluntary hospitals in New Hampshire at the time, and the idea of going to a hospital was something which had to be broached with the greatest discretion. At that time and for some years afterward, no laboratory was available except a place to boil a urine specimen. The project proved successful, however, under careful management. A cow was kept on the premises, also pigs and chickens as well as a vegetable garden.

Confidence on the part of the citizens in the doctors who sponsored the idea soon broke down the barriers of dread and fear, and it was not long before it became evident that the bed capacity of the little cottage was insufficient. The next step was taken in 1923, when the decision was reached that either the cottage must be enlarged or a new one erected. Mr. Martin again came to the rescue by offering $25,000 provided a like sum could be raised. Contributions totaled $35,000 which with Mr. Martin's gift made possible the new building as it stands today. Its dedication occurred on November 11, 1924. Later its capacity was again increased by about ten beds through the purchase of a nurses' home.

Again the curtain falls only to rise showing the same scene, the office of Dr. Clow in Wolfeboro. The time is the present, just a few hours later than the opening scenes which took place at the hospital. Doctor Clow is telling the story. "In those early days you had to 'sell' a patient on the idea of going to the hospital. Now they go of their own free will, and then send for the doctor."

Much of the success of Huggins has been due as already mentioned to efficient supervision, within and without. Having studied its workings within, some attention should be devoted to its contacts outside.

Seventeen trustees comprise the board, about half of whom are men and women living outside of Wolfeboro. A few are summer residents, people of means who spend their summers in camps on the lake, and who have grown immensely interested in what goes on at Huggins. Numerous substantial gifts for specific needs are received from such sources.

Committee Gives Practical Service

It is the executive committee, however, that actually is responsible for the hospital's affairs. This consists of five members, each having some specific responsibility. In addition to the chairman and the clerk, there is a finance officer, a property officer and a medical officer.

Close supervision is again made easier by the comparatively small area which the town covers. The property officer, it so happens, lives almost next-door to the hospital. Several times a week he stops in to see that everything is all right, and many a Sunday morning finds him examining the boiler, the steam plant or other of the physical appurtenances to assure satisfactory operation.

Similarly, the finance officer guards carefully the hospital's resources. The story of Huggins and the work it is performing is constantly being brought to the attention of other townships and financial aid solicited from individuals as well as the town itself.

The medical officer meets his own individual problems without interference from the others, except when such questions as may come up involve general policies. The attending staff comprises nine individuals, one of whom is a fellow of the American College of Surgeons and another a fellow of the American College of Physicians. In addition, however, there is a sizable courtesy staff which includes men nationally known in their respective fields who spend their summers in the vicinity and who send their patients to the hospital for treatment where they can be close at hand to watch their progress.

The hospital is fortunate, too, in having an unusually active ladies' aid, which meets regularly and performs various services such as care of the linen, supervision of uniforms and similar functions. Through sales and social events this auxiliary raises about $1,000 yearly.

Every possible effort is made to maintain interest not only on the part of the community as a whole in hospital work, but to promote a broader knowledge among the professional people. Each month hospital conferences are held, at which time doctors, nurses, dentists get together and listen to a paper read by one of their members on some topic of value to all. Sometimes these treat of the history of medicine, nursing and dentistry. On other occasions the discussion bears upon how hospital service can be improved. Nurses, married and in town, take part in these proceedings.

So much for the past and present. There is always the future. More space is already the crying need of everyone identified with Huggins. Plans are being made for an obstetric department separate from the rest of the hospital with doctors' offices on the first floor, thus making it possible for all doctors and dentists, too, to have offices there.

Then, growing demands upon the clinical services mean expansion in that direction. At present cancer and dental clinics are held once every two weeks. Twice yearly for two weeks each time, a medical clinic takes place, and each year at the close of school all the children of the community are rounded up for a check-up on tonsils and adenoids. Future expansion, therefore, follows the lines of a veritable community medical center.

"We have tried to do good work," are Doctor Clow's closing words as the final curtain falls on this Little Journey to Huggins. "To give more than we have received. One other thing, we have cultivated an interested group with money to give when some specific need is brought to their attention, and we see that some specific need is ready."

Ratio of Students to Graduate Nurses in Tennessee

A recent compilation of data about Tennessee schools of nursing shows that the number of student nurses to each graduate nurse employed ranges from one to fifteen, excluding two hospitals that conduct schools without employing any graduate nurses at all.

Two of the hospitals have almost as many graduates as students, according to the tabulation. One has three students to each graduate, six have four students to one graduate and the rest have higher numbers. Only one hospital has more than twelve students to one graduate and this one has fifteen. The median number of students to graduates for this group of 28 hospitals is 6.5.

A Nurse's View of Nursing Education

By NELLIE X. HAWKINSON, R.N.
Professor of Nursing Education, University of Chicago

Overproduction and undereducation are the two most serious problems confronting nurses today. Their direct cause is the apprenticeship system which has produced a paradoxical situation whereby there are too many nurses and yet too few

NURSING education has undergone critical analysis during the past two decades. During this period two outstanding surveys of nursing education have been made, one by the Goldmark Committee and the other by the Committee on the Grading of Nursing Schools. In addition, several other studies, less well known but nevertheless of considerable importance, have been carried on. I refer to such studies as the Cleveland Hospital and Health Survey, which included a study of nursing education, that of the committee on nursing education of the Association of American Medical Colleges, and the more recent investigation carried on in New York State under the direction of Dr. Harlan H. Horner, assistant commissioner for higher education, University of the State of New York.

To the recommendations set forth in the reports of these surveys, which express the thinking of some of the fore-thinkers in the field of nursing education and in closely related fields, and also to the more progressive schools of nursing which are making effective many of the recommendations of these committees, we must look for indications of forward movements in the field of nursing education.

Dr. C.-E. A. Winslow, professor of public health, Yale University, speaking before the Illinois State Nurses' Association four years ago, made the following statement: "All the studies made by the National League of Nursing Education, the Goldmark Committee and the Grading Committee lead up to one point, and that is that the training of nurses is a serious educational business . . . which must be attacked by those interested primarily in nursing education." This observation clearly indicates an important trend in nursing education. Our existing system has been weighed in the balance and found wanting and out of a recognition of its inadequacy has come this expression of need for a new type of education which will correct some of the weaknesses of our present system.

I shall not take the time to review the many and serious shortcomings of the apprenticeship system as revealed in the findings of the Goldmark Committee and the Committee on the Grading of Nursing Schools. Suffice it to say that this system which has placed upon schools of nursing the dual responsibility of educating students and providing nursing service for hospitals is, indeed, as the Goldmark Committee states, the crux of our problem, the heart of our difficulty. It is the direct cause of the two most serious nursing problems confronting us today, overproduction and undereducation. Operating as it has with little reference to either the needs of students or the needs of the community, it has produced the paradoxical situation with which we are now faced, that of having too many nurses and yet too few, thousands of nurses out of work while many nursing positions remain unfilled for lack of nurses with adequate preparation. As a solution to these serious problems all of the studies referred to offer practically the same remedial measure.

The Goldmark Committee in its report "Nursing and Nursing Education in the United States," published in 1923, emphasized the fundamental need of recognizing the school of nursing in the hospital as an educational department which definitely undertakes to give students a training calculated to meet the needs of their future potential patients as well as to care for the immediate patients in the hospital. It also encouraged the establishment of schools of nursing under university auspices so that their educational standards might be better safeguarded. The establishment of the Yale University School of Nursing was a direct outcome of the Goldmark study, and from the beginning it has been a pace setter in the field of nursing education.

In 1923, the Association of American Medical Colleges, after completing a two-year study of the education of nurses, went on record "as believing that nursing education should be more closely integrated with other educational fields. Nursing schools should be made to conform to college standards with all that is implied in this statement as to requirements for admission, type of teachers engaged, equipment and facilities available, requirements for advancement and graduation."

The same opinion is also expressed in the final report of the Committee on the Grading of Nursing Schools. This committee states that "the fundamental cure for the twin evils of overproduction and undereducation can be effected only by the development of nursing schools which are directed with a primary educational aim and animated by professional ideals. They must cooperate with hospitals but they must have their own management and their own budgets if they are to function as educational institutions and to meet the social needs of the community."

In the conclusion of all these committees we find expressed the need for the reorganization of schools of nursing so that students of nursing may be provided with the same educational privileges as are available to students in other professional fields. This move toward the development of nursing education on a professional level is, I believe, the most significant trend in nursing education today and one which will most certainly have a decided effect upon hospitals.

The Hospital's Contribution

I consider it important that this move toward the affiliation of schools of nursing with educational institutions be not interpreted as a criticism of hospitals. For over fifty years hospitals have assumed almost full responsibility for the education of nurses and, regardless of how educationally unsound our existing system may be, we should indeed be both ungrateful and shortsighted if we failed to recognize that hospitals have made a valuable contribution to the progress of nursing education in the past and will continue to do so in the future. The nursing care of patients will always be an important part of the education of the nurse and consequently whatever changes may come in the organization of schools of nursing, there will be the need for a close relationship with hospitals in order that student nurses may secure this essential experience.

Returning to a consideration of what is involved in the present trend toward the reorganization of nursing education on a professional basis, one has only to compare the grading committee's summarization of "what most schools of nursing are like," based on self-surveys made by 1,383 schools of nursing, with this same committee's recommendations pertaining to the essential conditions for a basic professional school to realize that the gap between what is and what should be is exceedingly wide and that some rather radical changes must be made in our present system if nursing education is to be brought up to a level which will compare favorably with professional education in other fields.

Requirements of a Professional School

The most needed changes indicated by all of the committees previously referred to have to do with such important factors as finances, organization, preparation of the faculty, qualifications of students and curriculum, and are based upon the generally accepted needs of every true professional school. In general, the conclusions of these committees with regard to the conditions essential for a professional school of nursing may be stated as follows: A school of nursing, to operate on a professional level, should have adequate funds for the establishment and maintenance of its program; a type of organization that will adequately safeguard the education of its students; a faculty with special preparation equivalent to that required of those holding similar positions in other types of professional schools; educational standards of entrance at least equivalent to those of a good college, and a curriculum based on the needs of the community.

A few independently organized and endowed schools of nursing, such as those at Yale, Western Reserve and Vanderbilt Universities, have already attained these essential requirements. They are outstanding examples of progressive education in nursing.

But our concern is not so much with these few university schools of nursing as with the 1,500 and more state accredited hospital schools of nursing. What changes are they facing? What effect will social demands for a more adequate type of preparation for nurses have upon their future? If a nursing school's right to exist should be determined only on the basis of its ability to provide adequate preparation for professional practitioners of nursing, then, judged on this basis, a large percentage of our so-called schools of nursing should either be closed or reorganized. Some, recognizing their inadequacy, have already closed. Many more will do so in the future. Of those remaining, the greater number must look forward to reorganization if they are to take their place with other professional schools.

The remarkable advances in medicine, public health and other closely related fields, rapidly

changing social conditions and changes within the nursing profession itself are constantly increasing the responsibilities of the graduate nurse, steadily enlarging the scope of her usefulness and creating the demand for a much broader type of education than was formerly considered necessary. It is the challenge of this ever broadening field of usefulness that has brought us to a realization that the apprenticeship system of education is inadequate for the preparation of professional nurses. It is, in the words of a noted educator, obsolete and must be superseded as soon as is practicable.

Let us consider for a moment what this transfer from the apprenticeship system to one more educationally sound would really mean. In the first place, it would necessitate the organization of schools of nursing as separate entities or units apart from the nursing services of hospitals so that the two distinct functions of educating student nurses and providing nursing care for the sick could be carried forward without one seriously interfering with the other. From the standpoint of organization, this is an entirely feasible plan. It has been worked out successfully by medical schools and also by independent university schools of nursing. The only limiting factor in making this plan effective is, as I see it, lack of adequate funds, and I am enough of an optimist to believe that in time this handicap, serious as it seems today, can be overcome through the cooperative efforts of all groups concerned—the public, hospitals, colleges and universities and the nursing profession itself.

What a Changed System Would Involve

Many other factors would also require revision in making a transfer from the apprenticeship system. For example, fewer and better qualified students would be admitted; the educational program would not be limited by the hospital's need for nursing service but would be based on the student's needs and would be broadened to include experience in such fields as communicable disease nursing, mental nursing and community nursing; hours of student practice would be shortened and would be more in harmony with what is expected of students in other professional schools; better instruction would be provided, particularly in the hospital wards; in short all those conditions would be provided which are considered essential for every professional school.

In this connection it may be of interest to note that the central curriculum committee of the National League of Nursing Education, now engaged in an extensive revision of the "Curriculum for Schools of Nursing," recommends that the nursing curriculum be based on one to two years of general education beyond high school, or academic education combined with professional in such a way as to provide an equivalent background of general education, and that both the content of the curriculum and the teaching methods be adjusted to this level. This places the professional education of the nurse on the senior college level which is consistent with the practice effective in all other professional fields.

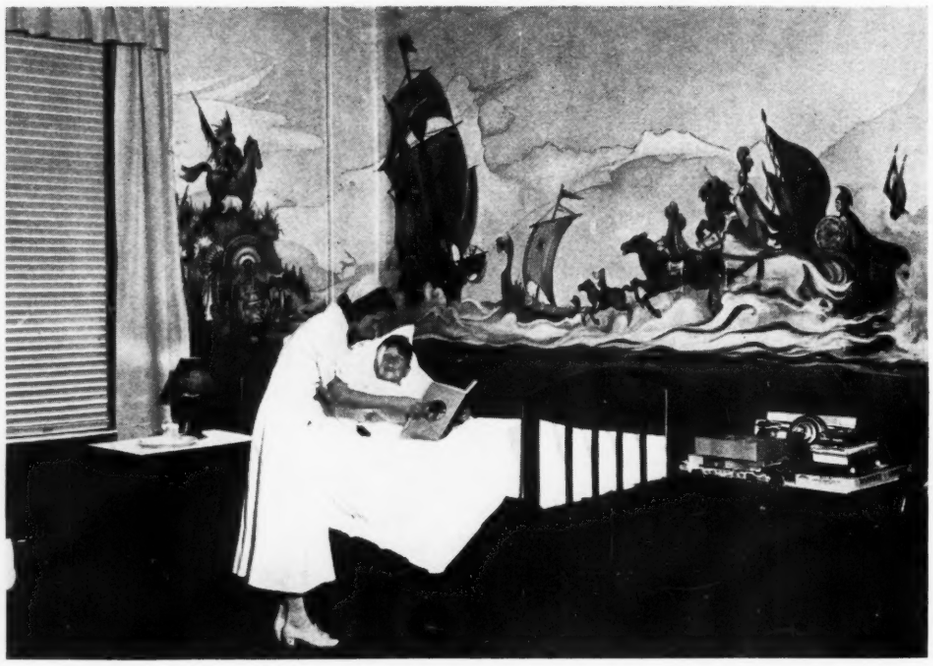
The extent to which this development of nursing education on a professional level will affect hospitals is evident when one recalls that nearly all schools of nursing are owned and controlled by hospitals. As has already been stated, to many of them it will mean closing their schools and nursing their patients with a graduate staff. To others, it will mean a gradual reorganization of their schools, bringing them up to a professional level with the substitution of graduate and supplementary service for some work now done by students.

Many Groups Must Lend Aid

How these changes are to be made is primarily a question of economics and outside the scope of this discussion. However, it is obvious that hospitals cannot make these changes alone. They must have the help of all groups which are concerned with the problems of health and professional education. Dr. Samuel P. Capen, chancellor, University of Buffalo, in an article on "Who Is Concerned With the Reform of Nursing Education?" in the December, 1934, issue of The MODERN HOSPITAL, states that the responsibility for nursing reform should be assumed by hospital authorities, both board members and executives, officers of universities, the community and the profession itself. It is his opinion that no hospital board member or hospital executive dare be satisfied until the school for which he is responsible is either converted into a genuine educational institution with whatever it may need of additional financial resources and educational affiliations, or is discontinued.

That these changes which have been suggested cannot be made, even with the help of all these groups, today, tomorrow or even next year, but will have to be effected gradually, I am well aware. But that they must be made eventually, I am fully convinced. The need for the reform of nursing education has grown out of constantly increasing social demands which we must recognize if graduate nurses are to be prepared to function effectively and to participate cooperatively in carrying forward the many phases of a modern community health service.[1]

[1]Read at the meeting of the Tri-State Hospital Association, Chicago, May, 1935.



Various methods of travel are illustrated in this fanciful picture, including knights on horseback, couriers, chariots, Viking ships, galleons and mounted Indians. Mr. League has prepared a story about the mural which he tells children when he visits the hospital.

The Ravenswood Road to Recovery

CHILDREN who have the misfortune to need hospital care soon require entertainment of some kind. Ravenswood Hospital, Chicago, has recently had the good fortune to have part of this task taken off the backs of the nurses and put on the walls — yes, literally.

The Chicago artist, Jefferson League, has long been interested in art for sick children. As a child, he spent three years on a sick bed. While confined to bed he drew pictures bringing a host of lovely playmates down to his sketch pad. One day he promised his kindly old doctor that when he was well and grew up he would be an artist and would paint for other sick children who weren't able to bring fairyland out of their pencils or paint boxes.

In Ravenswood Hospital he has kept his promise. The walls of the children's ward are covered with his murals. Many of the well known nursery and fairy characters are depicted as well as others of historical interest. The first picture to attract attention on entering the room is Jack and the Beanstalk. Little Red Riding Hood, the Three Little Pigs, the Knight on the Black Horse and many others may be found in this mural. In the corner of the room is a mural depicting the characters of a circus. Some of the acrobats at the Century of Progress exposition posed for various of the characters. An elephant, clowns, tight-rope walkers and a magician are included.

Medical Records—Are They Worth the Price?

By JOHN R. MANNIX
Assistant Director, University Hospitals, Cleveland

The author estimates the cost of medical records for the United States at the staggering figure of $8,000,000. He questions if we are getting value for our money. To justify the expense he believes these records must cease to be merely factual and their potential value as interpretive documents must be utilized by hospitals

THE cost of maintaining medical record systems in hospitals has increased to a point where from an economic standpoint alone, hospital administrators should take inventory to determine whether all possible benefits are being obtained.

It seems that such an inventory would show that hospitals are neglecting one of the greatest potential benefits that may accrue as the result of a complete medical record system.

The average direct cost of medical records service in Cleveland hospitals is seven cents per patient day. This cost includes only the cost of salaries of the historian and medical stenographers and the cost of printed forms and supplies. It does not include any charge for the services of the attending and resident physicians or nursing or other professional personnel in recording the data, nor does it include any overhead such as housekeeping, and maintaining of space and equipment for the medical record department. The *Journal of the American Medical Association* for March 30, 1935, shows that acute hospitals in Ohio (not including mental and tuberculosis hospitals or hospital departments of institutions) are rendering 4,000,000 days of service annually. Granting that the direct medical record cost throughout Ohio is the same as the Cleveland average, the direct cost for the state would be $280,000 a year. It is probably conservative to estimate the total cost at twice the direct cost, so that the total cost for Ohio would be over $500,000. On this basis, the cost for the United States is over $8,000,000.

The question arises as to whether hospitals and the medical profession are receiving benefits to justify this great expense. We agree that certain records are necessary during the treatment of a given patient; we agree that the hospital must maintain a case history for its own legal protection; we know that medical records have aided in subsequent treatment to individual patients as well as members of their families; we know that in many of our institutions research is being conducted on various types of disease and that medical records of individual cases greatly aid in such research.

Are there other ways in which medical records can be of use in medical and hospital practice? It seems that there is another way, and this way may be of more importance in medical and hospital practice than any other.

Accountants like to differentiate between bookkeeping and accounting. Bookkeeping is defined as the act of making an orderly recording of the financial transactions of an organization, and accounting, as an interpretation of the financial transactions. Now it would appear that hospitals carry on a medical bookkeeping system, and not a medical accounting system.

The modern hospital makes an orderly and accurate recording of the history and treatment of patients, and to be sure it classifies disease, operations, injuries and deaths. In addition, it records patient admissions, days of service, x-ray examinations, laboratory examinations. Then it proceeds to file such records in expensive filing equipment in the basement or attic.

There is, so to speak, little or no accounting—there are no interpretive records. The charts are completed, the case classified on the diagnosis and other indexes. Patient days, admissions and other data are compiled but remain separate records; their relation to each other is seldom shown.

Now, I should like to suggest that we give consideration to the development of a monthly report which would show such data as the following:

Discharges as to classification of disease
Discharges as to condition at time of discharge

Recovered	Newborn infants
Improved	Deaths — institutional
Unimproved	Deaths—forty-eight hours
Observation cases	Stillbirths

Surgical operations and type of anesthesia
X-ray examinations
X-ray treatments
Laboratory examinations
Physical therapy treatments

All these data should be tabulated by service, and should show a comparison with the same month the previous year. Data should also be developed for the year to date, and this compared with the same period in previous years.

Data should be developed to show the length of stay of in-patients on each of the services and this compared with past periods. Ratios of x-ray examinations and laboratory examinations to patients served on each of the services should be compiled.

In other words, we should have a medical report similar in scope to our financial report. We should have a report of our medical services which would enable our staffs as well as the administration to evaluate the medical performance of our institutions.

A quantitative monthly report of this type distributed to members of the medical staff and reviewed at the medical staff meetings would suggest qualitative medical study and research and would probably result in a closer working relationship between the medical staff and the medical record department.

Such a record would serve as a yardstick of performance which would justify the expenditures we are now making for medical records.[1]

[1]Read at the meeting of the Ohio Association of Medical Record Librarians.

Rules for Economical Heating

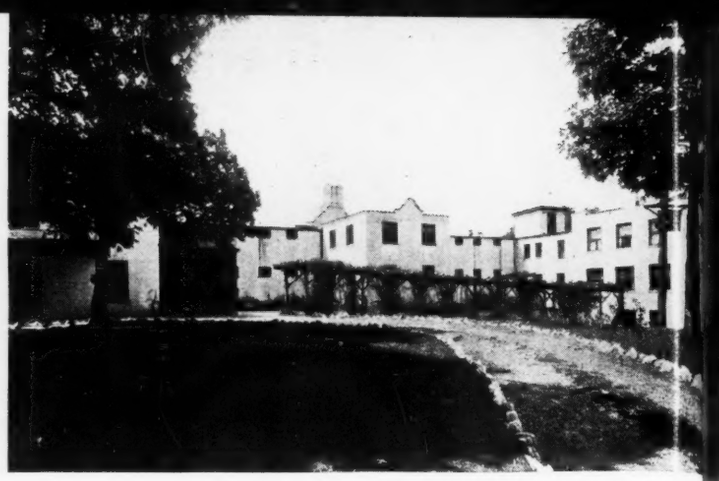
WORKABLE suggestions for the reduction of heating costs are contained in a recent article in *Buildings and Building Management* by J. Earl Seiter. Most of these are adaptable to hospital usage:

1. Weatherstrip all windows and calk all window frames.
2. Provide revolving or vestibule doors on all entrances. Separate shipping and receiving rooms by partitions so that the ever open large doors will not ventilate the entire building.
3. Keep the radiation near the outside walls, under the windows, if possible.
4. Eliminate all unnecessary ventilation. Ventilating equipment is sized to meet extreme requirements. Don't supply ventilation to a theater or an auditorium adequate for an audience of 1,000 when there are only 100 present.
5. Determine the hours that heating is required during the day and see that the steam is shut off for the maximum time at night, on Sundays and holidays.
6. Shut steam off entirely in unoccupied sections of the building, taking care to avoid freezing of plumbing.
7. Shut off steam during the day whenever possible. During the year steam can be shut off about 55 per cent of the total daytime. An automatic control will do it perfectly, but it can be done by hand with amazingly good results.
8. Determine the temperature required for the occupancy of the building. Do not heat a storage garage to the temperature required in a hospital ward.
9. Provide some good means of temperature control. No building can afford to be without such a control.
10. In a hot water heating system, keep the temperature of the water down to correspond with existing outdoor temperatures.
11. In a vacuum system, maintain a high vacuum. If this is not possible, locate and eliminate all leaks.
12. Install separate lines for those parts of the building that require long-hour or all-night heating. It is much cheaper than heating the entire building all night.
13. See that the entire system responds rapidly when the steam is turned on. Locate and eliminate the cause of any sluggish circulation. Balance the radiation, provide adequate air elimination, and correct any trapped run-outs to provide quick system drainage.
14. Keep the system in good repair. Worn, damaged or defective valves and traps will not function properly.
15. Cover all steam pipes.
16. Do not cover or otherwise obstruct the free circulation of air around the radiators; to do so seriously reduces the heating capacity of a radiator.
17. Use the heat in the condensate for hot water or some other useful purpose.
18. Provide thermometers and recording pressure gauges so that the engineer can operate the system with full knowledge of just what he is doing and what he is accomplishing.
19. Make all valves and controls convenient and accessible, either directly or through remote control. It is only human nature to delay and avoid doing that which is inconvenient.
20. Keep a consistent daily record, based on weather requirements, and watch it every day.
21. Know the system and understand its functions and operations.
22. Control the heating supplied to water tanks located on or above the roof. Such tanks require heat to prevent freezing. No heat is required when the outdoor temperature is above 32° F.
23. Investigate every complaint of "No Heat," find the cause and correct it. Do not overheat an entire building to correct a local condition in one room.

THIRTY-SEVENTH ANNUAL CONVENTION OF A. H. A.

MUNICIPAL AUDITORIUM, ST. LOUIS

St. Louis Children's Hospital.



Country Department of St. Louis Children's.

Where to Go and What to

A FINE, new air conditioned auditorium with beautiful appointments and assembly facilities to meet the most hectic schedule is what St. Louis offers to the forthcoming conventions of the American Hospital Association (September 30 to October 4) and allied organizations. Meetings are scheduled also for the Protestant Hospital Association, the College of Hospital Administrators, the occupational therapists, nurse anesthetists, medical social workers, hospital dietitians and the Children's Hospital Association.

When he is not taking part in one of the many meetings which fill the convention program, the visiting administrator will find much to engage his interest, both from a professional point of view and otherwise.

Within a short distance of the auditorium are St. Louis' two important medical schools with their hospitals—St. Louis University with Firmin Desloge and St. Mary's Hospitals, St. Mary's Infirmary and Mount St. Rose Sanatorium for the tuberculous; and Washington University, with Barnes Hospital. Firmin Desloge is important because of its attempt to integrate an out-patient department with a hospital for patients of moderate means. Barnes Hospital offers to graduate nurses special courses in anesthesia and operating room technique, and to college graduates in home economics, specially planned work in dietetics.

The Shriners' Hospital for Crippled Children, another of the group including Barnes, provides an interesting example of a specialized hospital. Jewish Hospital, St. Luke's, the Lutheran Deaconess, and a number of others in the same vicinity go to make up a hospital center which deserves the attention of each member of the convention.

Missouri Pacific Hospital has an unusual case record system of health records, data concerning injuries and medico-legal information. This hospital is one of the two railroad owned institutions in the city.

For those who seek a more frivolous outlet for their energies than visits to hospitals, St. Louis offers a number of possibilities. The famous Shaw's Garden, as the Missouri Botanical Garden is popularly called, contains the largest collection of plant life in the western hemisphere. More than 11,000 species of plants find place in it; the section within St. Louis itself covers seventy-five acres. The amateur botanist will find it well worth the short ride necessary to reach it.

St. Louis Cathedral, not far from either of the university hospital groups, is one of the largest

Alexian Brothers Hospital.

De Paul Hospital, St. Louis.

City Hospital, St. Louis.

Nurses' Home at Barnes Hospital.

to See in Saint Louis

and most magnificent cathedrals in the United States. Its mosaic work is of particular note.

Just west of the Barnes Hospital group is Forest Park, with its fine art museum, municipal theater (seating 10,000 persons) and Jefferson Memorial Building, wherein can be seen the original documents concerned with the Louisiana Purchase, a large portion of the manuscripts of the Hamilton-Burr controversy, many of the manuscript records of the Lewis and Clark expedition, and the trophies, gifts and medals showered upon Lindbergh after his flight across the Atlantic.

The Zoological Gardens will be found here, also, and merit a visit. They are constructed to give the animals the greatest possible freedom, and conditions approximating as nearly as possible those found in their natural haunts.

Some Historic Features

If time permits, a trip to the east edge of the city should prove of interest. Steamers may be boarded here for trips either up or down the Mississippi, or inspection may be made of the Old Courthouse, where are the stone auction block from which slaves and other personal property were auctioned, and the courtroom in which Dred Scott's famous case for freedom was begun. The Old Cathedral, another historic feature, is just a little south and east of the Courthouse.

Residents of St. Louis recommend a visit to the Lake of the Ozarks, with its $30,000 electric power dam. It is only a few hours' drive from the city, and offers fishing, swimming and boating. They also suggest a drive through the city's residential section, of which they are proud, telling us that 39 per cent of the city's inhabitants live in their own homes.

A sight-seeing tour of St. Louis would be incomplete without a drive through the parks and a trip to one of the city's major industries—the breweries. The largest of them invites visitors to its plant, where guides show them through at 9:30 a.m. and 3:30 p.m.

For the visitor who likes active sports, there are several fee golf courses within easy reach of the downtown district; horses may be secured for riding on the bridle paths of Forest Park, and tennis courts are available on payment of a permit fee.

There is no dearth of occupation for the few free hours the convention visitor may have. It becomes instead a matter of choosing among the many opportunities for relaxation.

St. Ann's Maternity Hospital.

Jewish Hospital, St. Louis.

Here Is the A.H.A. Convention Program

General Business Session

Monday, 2:00 p.m.

Chairman: Robert Jolly, F.A.C.H.A. president.

Reports: Trustees; treasurer; constitution and rules; membership; council on community relations and administrative practice; autopsies; unfair competition; institute for hospital administrators; regulations as applied to membership; National Hospital Day; clinical records; simplification and standardization of hospital furnishings, supplies and equipment; workmen's compensation and liability insurance; hospital income and bed occupancy; physical therapy; joint committee of national hospital associations.

New business.

President's Session

Monday, 8:00 p.m., Jefferson Hotel

Address: Robert Jolly.

Conferring of National Hospital Day Award by Albert G. Hahn, Deaconess Hospital, Evansville, Ind., chairman, National Hospital Day Committee.

Small Hospital Section

Tuesday, 9:00 a.m.

Chairman: Edna D. Price, R.N., Emerson Hospital, Concord, Mass.; *Secretary:* James A. Hamilton, Mary Hitchcock Memorial Hospital, Hanover, N. H.

Address: Psychology for Nurses in Rural and Small Hospitals, Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.

Address: Opportunities for Community Service Other Than Hospitalization, A. F. Branton, M.D., Willmar Hospital, Willmar, Minn.

Address: Social Service in Small Hospitals.

Round Table: G. Harvey Agnew, M.D., secretary, department of hospital service, Canadian Medical Association, Toronto, Ont., leader.

Dietetic Section

Tuesday, 9:00 a.m.

Chairman: Lenna F. Cooper, Montefiore Hospital, New York City; *Secretary:* Elizabeth Miller, Philadelphia General Hospital, Philadelphia.

Program to be announced.

Tuberculosis Section

Tuesday, 9:00 a.m.

Chairman: W. C. Reineking, M.D., Lake View Sanatorium, Madison, Wis.; *Secretary:* H. A. Pattison, M.D., Potts Memorial Hospital, Livingston, N. Y.

Address: Means and Methods for Securing Uniformity in Films, S. Reid Warren, Jr., Philadelphia.

Discussion: D. O. N. Lindberg, M.D., Decatur, Ill.

Address: Interpretation of Chest Films With Special Reference to Tuberculosis, H. Kennon Dunham, M.D., Cincinnati.

Discussion: Leroy Sante, M.D., St. Louis.

Address: Differential Diagnosis of Chest Films, Evarts A. Graham, M.D. and J. J. Singer, M.D., St. Louis.

Discussion: Benjamin L. Brock, M.D., Waverly Hills, Ky.

Legislative Session

Tuesday, 2:00 p.m.

Presiding: Robert Jolly, president.

Report: Legislative Reference Committee, A. M. Calvin, Midway and Mounds Park Hospitals, St. Paul, Minn., chairman.

Business session.

Out-Patient Section

Tuesday, 2:00 p.m.

Chairman: E. L. Harmon, M.D., University Hospitals, Cleveland, Ohio; *Secretary:* Robert Nye, M.D., Jefferson Medical College Hospital, Philadelphia.

Report: Out-Patient Committee, Frederick MacCurdy, M.D., Vanderbilt Clinic, New York City, chairman.

Discussion of above report on nationwide survey of facilities for care of indigent and near-indigent ambulatory sick and formulation of policies in this field.

Round Table on Accounting and Statistics for Small Hospitals

Tuesday, 2:00 p.m.

Leader: C. Rufus Rorem, Ph.D., Julius Rosenwald Fund, Chicago.

Discussion Topics: Uniformity in Hospital Accounts; Depreciation; Free Work; Balance Sheet; Inventories; Cost Analyses; Accounts Receivable; Cost per Patient Day; Percentage of Occupancy, etc.

Round Table on Administrative Problems in the Tuberculosis Sanatorium

Tuesday, 2:00 p.m.

Chairman: W. C. Reineking, M.D., Lake View Sanatorium, Madison, Wis.; *Secretary:* H. A. Pattison, M.D., Potts Memorial Hospital, Livingston, N. Y.

Address: The Adequate Medical Staff in Numbers and Quality, George Thomas Palmer, M.D., Springfield, Ill.

Address: The Adequate Nursing Staff — Graduate and Nongraduate Nurses — Employment of Tuberculous Ex-Patients, W. J. Bryan, M.D., Mt. Vernon, Mo.

Address: Rehabilitation of Patients in the Sanatorium, Robinson Bosworth, M.D., Rockford, Ill.

Address: The Employment of Ex-Patients, H. I. Spector, M.D., St. Louis.

Address: Dietetics in the Smaller Institution.

Trustees' Section

Tuesday, 8:00 p.m., Jefferson Hotel

Chairman: Frank C. Rand, president, Barnes Hospital, St. Louis.

Administration Section

Wednesday, 9:00 a.m.

Chairman: Allan Craig, M.D., F.A.C.H.A., Charlotte Hungerford Hospital, Torrington, Conn.; *Secretary:* Joseph G. Norby, Fairview Hospital, Minneapolis, Minn.

Report: Public Education Committee, Allan Craig, chairman.

Address: Service, Social and Teaching Problems of Today, Nathaniel W. Faxon, M.D., Massachusetts General Hospital, Boston.

Address: Hospital Hazards, Lewis A. Sexton, M.D., Hartford Hospital, Hartford, Conn.

Discussion: William H. Walsh, M.D., hospital consultant, Chicago.

Address: A New Definition of Free and Part-Pay Hospital Service, J. V. Buck, St. Luke's Hospital, Spokane, Wash.

Address: Trends in Departmental Services in Hospitals, M. T. MacEachern, M.D., American College of Surgeons, Chicago.

Small Hospital Round Table

Wednesday, 9:00 a.m.

Leader: Bryce L. Twitty, Dallas, Tex.

Children's Hospital Section

Wednesday, 9:00 a.m.

Chairman: Robert B. Witham, Children's Hospital, Denver, Colo.; *Vice Chairman:* Gertrude R. Folendorf, R.N., Shriners Hospital for Crippled Children, San Francisco, Cal.; *Secretary:* Agnes O'Roke, R.N., Kosair Crippled Children Hospital, Louisville, Ky.; *Chairman, Local Arrangements Committee:* Edith F. Bateman, Shriners Hospital for Crippled Children, St. Louis.

Address: Bert W. Caldwell, M.D., executive secretary, American Hospital Association, Chicago.

Address: The Conduct of a Convalescent Department of a Children's Hospital, W. McKim Marriott, M.D., physician in chief, St. Louis Children's Hospital, St. Louis.

Address: Administrative Trends in Children's Hospitals, Robert E. Neff, University of Iowa Hospitals.

September 30—October 4

Address: Social Service Problems in Children's Work, Lelia I. Dickinson, head worker, pediatric service, Washington University Clinic and Allied Hospitals, St. Louis.

Address: Group Plan in a Hospital Environment, Anne M. Smith, director of children's play, Children's Memorial Hospital, Chicago.

Visit to Ridge Farm.

Nursing Section

Wednesday, 2:00 p.m.

Chairman: Sister Mary Therese, John B. Murphy Hospital, Chicago.

Address: Methods of Analyzing the Nursing Service in Relation to the Patient's Needs, Blanche Pfefferkorn, director of studies, National League of Nursing Education, New York City.

Address: What Is the Educational Responsibility of State Boards? Mrs. Ada Crocker, R.N., executive secretary, Illinois State Nurses Association, Chicago.

Discussion: Grace Phelps, R.N., Doernbecker Memorial Hospital for Children, Portland, Ore.

Address: Needed Changes in Nurses' Curriculum, Sister Mary Reginald, R.S.M., nursing school supervisor, Grand Rapids, Mich.

Address: Does Public Health Belong in the Student Nurse's Curriculum? Harriet Fulmer, R.N., rural public health nursing, Cook County, Ill.

Discussion: Fannie Brooks, University of Illinois, Chicago.

Volunteer Service Round Table

Wednesday, 2:00 p.m.

Leader: R. C. Buerki, M.D., Madison, Wis.

Round Table on Hospital Libraries

Wednesday, 2:00 p.m.

Leader: Perrie Jones, supervisor of state institution libraries, St. Paul.

Report: Hospital Libraries, Perrie Jones.

Address: Hospital Library Service: Its Present Status and Possible Future, Charles H. Compton, assistant librarian, St. Louis Public Library, St. Louis.

Address: Costs of Hospital Libraries, Robert E. Neff, F.A.C.H.A., State University of Iowa Hospitals, Iowa City, Iowa.

Address: The Hospital Library in Relation to Psychiatric Research, M. C. Petersen, M.D., asistant superintendent, St. Peter State Hospital, St. Peter, Minn.

Address: A School Library in a Children's Hospital, Marie Rainey, librarian, Gillette State Hospital for Crippled Children, St. Paul, Minn.

Annual Banquet and Ball

Wednesday, 7:00 p.m., Jefferson Hotel

Presiding: Robert Jolly, F.A.C.H.A.

Symposium on the Mechanical Divisions of Hospital Operation

Thursday, 9:00 a.m.

Chairman: S. Frank Roach, superintendent of laundry, Medical Center, Jersey City, N. J.; *Secretary:* Anthony A. Fette, City Hospital, Cincinnati, Ohio.

Address: The Care and Preservation of Fixed Equipment, Plumbing and Sterilizers, L. B. Stine, Crane Company, Chicago.

Address: Value of Recording Instruments to Regulate the Distribution of Steam, Electricity and Hot Water From a Central Station, William H. Driscoll, M.E., vice president, Thompson - Starret Company, New York City.

Address: A Minimum Washing Formula for the Preservation of Hospital Linens, H. F. Neumann, Colgate-Palmolive-Peet Co., Jersey City, N. J.

Address: Positive Dividends From the Care Exercised in Preparation for Painting, J. T. Lawrence, Mitchell-Rand Company, Jersey City, N. J.

Summary: Joseph C. Doane, M.D., medical director, Jewish Hospital, Philadelphia, and editor, The Modern Hospital.

Round Table on General Hospital Problems

Thursday, 9:00 a.m.

Leader: M. T. MacEachern, M.D., Chicago.

Social Service Section

Thursday, 9:00 a.m.

Chairman: Eleanor Cockerill, Barnard Free Skin and Cancer Hospital, St. Louis; *Secretary:* Isabel Bering, Washington University Clinics and Allied Hospitals, St. Louis.

Address: Widening Horizons in Public Health Service, C. H. Lavinder, M.D., Washington, D. C.

Discussion: Antoinette Cannon and Robert E. Neff.

Construction Section

Thursday, 2:00 p.m.

Chairman: Lucius R. Wilson, M.D., John Sealy Hospital, Galveston, Tex.; *Secretary:* Mabel W. Binner, Children's Memorial Hospital, Chicago.

Address: Hospital Painting, F. R. Bradley, M.D., assistant superintendent, Barnes Hospital, St. Louis.

Discussion: J. Dewey Lutes, F.A.C.H.A., Ravenswood Hospital, Chicago.

Report: Hospital Planning and Equipment, Charles F. Neergaard, hospital consultant, New York City, chairman.

Discussion: Arthur C. Bachmeyer, M.D., University of Chicago Clinics, Chicago.

Address: Hospital Elevators, H. Eldridge Hannaford, Samuel Hannaford and Sons, architects, Cincinnati.

Discussion: Clarence J. Cummings, Tacoma General Hospital, Tacoma, Wash., and Austin D. Jenkins, Puckey and Jenkins, architects, Chicago.

Report: Air Conditioning, C. W. Munger, M.D., Grasslands Hospital, Valhalla, N. Y., chairman.

Discussion: R. H. Bishop, Jr., M.D., University Hospitals, Cleveland.

Address: Hospital Lighting, William H. Walsh, M.D., hospital consultant, Chicago.

Discussion: Robert E. Neff, F.A.C.H.A., State University of Iowa Hospitals, Iowa City, Iowa.

Report: Resolutions Committee, William H. Walsh, M.D., chairman.

Round Table on Mechanical Plant and Publicity

Thursday, 2:00 p.m.

Leader: Donald C. Smelzer, M.D., Philadelphia.

Round Table on Social Service

Thursday, 2:00 p.m.

Demonstration: Teamplay in Treatment; also addresses.

Public Hospital Section

Thursday, 8:00 p.m., Jefferson Hotel

Chairman: Charles E. Remy, M.D., F.A.P.A., F.A.C.H.A., Minneapolis General Hospital, Minneapolis, Minn.; *Secretary:* Fraser D. Mooney, M.D., Buffalo General Hospital, Buffalo, N. Y.

Report: Public Health Relations Committee, W. S. Rankin, M.D., Duke Endowment, Charlotte, N. C., chairman.

Address: Governmental Methods of Providing Care for the Indigent Sick in Canada Compared With the United States, G. Harvey Agnew, M.D., secretary, department of hospital service Canadian Medical Association, Toronto.

Address: Past, Present and Future Status of Governmental Hospitals in the Care of the Indigent Sick and Their Relation and Effect Upon Nongovernmental Public Hospitals, Nathaniel W. Faxon, M.D., F.A.C.H.A., Massachusetts General Hospital, Boston.

Address: The Scope and Relationships of General Hospitals, Michael M. Davis, Ph.D.

Discussion: S. S. Goldwater, M.D., commissioner of hospitals, New York City.

Closing Business Session

Friday, 9:00 a.m.

Presiding: Robert Jolly, president.

Induction of new officers. Unfinished business. New business.

Editorials

Men May Come and Men May Go—

THE hospital board of trustees must usually devote most of its concern to keeping the hospital financed. The physician and surgeon are engrossed in the patient. And the principal responsibility for the management and progress of the hospital itself devolves upon the administrator.

Nor is that responsibility a simple one. The administrator must be an astute business man to fill an ever increasing need for equipment and service from a limited and not too flexible budget. He must be a genius in administration to maintain harmony in an organization made up of every class of worker, from the professional man to the day laborer. His insight into the problems of medicine and surgery must be deep enough to enable him to cooperate in their solution. Further—and all too frequently forgotten—he needs a thorough knowledge of methods of developing amicable community relations, because his institution is essentially of the community and needs its support and good will.

It takes a superior man with adequate training to provide these diverse qualifications. A minister who is too incompetent to keep a church, or a man whose business ability is so slight that he cannot avoid bankruptcy, is scarcely the person to offer them. However, we still find too many unqualified people in the field. They cannot be expected to make any marked contribution to general progress, or even to do their specific jobs well, and they have made some serious mistakes.

Of course, even the able administrators, many of whom find it necessary to set up their own theorems before they can begin to solve their problems, make mistakes. Usually these result from too much introspection, not enough objectivity in point of view; too much consideration of the job as it relates to the hospital, rather than the hospital as it relates to the public. Progress lies in evolution, in revision of service.

These changes and revisions, however, should be carefully weighed and considered before they are set before the public. Sound changes are not the kind usually advocated by the incompetents, who, having failed under one system, shout for a new one. Because these are generally men who assume that if they cannot make a success of an independent hospital, no one can. "The public will not support voluntary hospitals. Therefore the voluntary hospitals should be supported by the government." They do not say, of course, that most people believe a government job to be less exacting; and that incompetent people like government jobs, where the competition is not so keen. Neither do they call attention to the leveling power of government control.

The bulk of progress in American hospitalization has been contributed by independent and voluntary hospitals under able administrators. In most departments they have been leaders in the growth of a hospital system which we believe is second to none. If an occasional hospital is retrogressing, it should examine its program for service and its methods for enlisting public interest and support. Inefficient administration should not condemn the system. If a change is to be made it should be made first in the personnel.

Today vigorous leaders are boldly attacking the littleness, the pettiness, and the smugness of incompetent and unqualified administrators who are sometimes well entrenched. The weaklings who cannot understand that development of the voluntary hospital is dependent upon rationalization of service to accord with the realities of present day society will soon be going. They will write their own tickets out. But the voluntary hospital with a real community program and with able and courageous administration will remain.

Social Security and Charitable Corporations

THE signing of the Social Security Act marked a definite step toward attempting to alleviate the hardships of unemployment and old age. In addition, the act provides a substantial encouragement to the development of better public health service. The constitutionality of the act as a whole and of its various sections will doubtless soon be argued before the Supreme Court.

Hospitals and certain other charitable institutions, acting through their official associations, sought and obtained exemption from the payment of taxes for the support of old age and unemployment insurance. They asked furthermore that their employees be given the benefit of such insurance but this request was denied. Therefore hospital employees, except those few working for proprietary institutions, will not be protected under this act.

There are reasons why hospitals with their low employee turnover and stable employment should not have been lumped with industries with high labor turnover and much unemployment. However, a number of people in hospitals and other charitable organizations regretted this exemption on the ground that social agencies should be the first to help in mitigating problems of old age and lack of work.

However, the act is law. It is now clearly the duty of hospitals to do on some voluntary basis what they are not compelled to do. The loyal, conscientious, hard working people who constitute most of the personnel of our hospitals should not be penalized because they are working in the interests of a community organization rather than one run for private profit.

Shirking Responsibility

THE ghost of unpaid bills and shrinking incomes has stalked unchallenged for half a decade throughout the hospital field. In its wake has followed a devastating psychology which has seemed to justify a compromise with the unethical, the questionably honest.

To save the hospital at any cost has too often been the decision of the emotionally disheveled superintendent and the board of trustees. The first necessity has seemed to be to increase the income of the hospital, its expenditures having been cut often far beyond reason. To this end its doors have too often been thrown open to physicians of all degrees of skill and even of doubtful character.

It is argued by some that if the patient is willing to submit to a major operation at the hand of a poorly trained surgeon why should the hospital interfere in the business of either. Such an argument is fallacious in the extreme. The institution, not the surgeon, is sure to be censured if disaster follows an attempt at a surgical cure. "The patient succumbed in hospital X" says the public without comment as to the part the doctor played in the tragedy.

The hospital is responsible to its public for furnishing a safe and highly skilled treatment in the case of every patient, high or low, whom it admits. It cannot sublet this responsibility to its staff singly or collectively. If it allows unsafe and poorly trained physicians to operate in its clinics and if by so doing it jeopardizes the life of a single patient for the sake of securing a tenant for a private room, it sinks to a despicable level of ethical degradation. No effort at mental evasion of the institution's duty can circumvent this conclusion. To permit an injustice to be done within the hospital walls in order to increase its income is certainly bartering its birthright for a mere mess of pottage.

Computing Postmortem Percentages

FROM time to time there appears in the institutional and medical press a statement covering the postmortem percentages of hospitals. These statistics in some instances reach a surprisingly high level. Not a few hospitals report that they are bringing to the autopsy table as high as 80 or 90 per cent of their institutional deaths. But such statistics are sometimes wholly misleading because too often hospitals adopt peculiar and inexact methods in preparing their published autopsy percentages.

The American Medical Association directs that in computing postmortem figures, which it insists in approved hospitals shall not fall below 15 per cent, stillbirths and coroner's cases shall not be included. Sometimes hospitals in their anxiety to make a creditable showing exclude private patients and even those dying within twenty-four hours after admission. It is not unusual for all of the latter type of patients to be declared coroner's cases. Some hospitals even exclude all coroner's cases in their computations except those in which they secure an autopsy permission.

Such practices are difficult to justify. No institutional autopsy percentage can be looked upon as reliable unless in its computation the total number

of hospital deaths, exclusive of the type above mentioned, is employed as a divisor and the number of autopsies secured as the dividend. To adopt inaccurate and evasive tactics in this matter is as unethical and untruthful as if dollars or other important articles of value were at stake. It is a discredit to the hospital deliberately to publish any statistics that are incorrect and to endeavor to attract the favorable comment of the institutional and scientific world by so doing. Honest and accurate statistics are the very foundation of economic and scientific progress in the hospital world.

Yardsticks for the Visiting Staff

THE staff should be reappointed annually. Perennial or automatically appointed staffs are not always the most alert or the most scientific. The ever present necessity of working and progressing to retain a hospital appointment is a stimulus to good medical work.

But how may a board or a superintendent recognize an efficient staff man? Not always by the size of his clientele shall he be known. The blatant advertising quack numbers his patients by the score. Not by the standing of his family in the social register or by the financial rating of the individual should a physician be judged. Certainly, by his personal probity, by his scientific training and skill, by the signs of his devotion to duty, by his observance of hospital rules, by his attendance at staff conferences, by his ability as a teacher and, lastly, while not unimportant but certainly not overwhelmingly preponderant, by the number of private patients referred to the hospital.

Works, not words; medical humility, not self-sufficient arrogance; constancy of purpose, not the pursuit of scientific butterflies — these are distinguishing traits of the good staff man.

When the Board Is Dissatisfied

THERE is apparently no more precarious profession than that of the hospital administrator. His tenure of office is, unfortunately, in many instances brief. Too often this fact cannot be explained by any serious personality or professional defect of his own. Sometimes, however, difficulties arise because of an unfortunate personal conflict with one or more board members without any real fault lying on either side.

Before matters reach an impasse there are sure signs of board dissatisfaction which the superintendent may easily detect. His responsibilities may be transferred to someone else or lack of confidence in him may be shown by a failure to consider his recommendations seriously. These things presage little good.

Such evidences of board unrest do not increase the executive's sense of personal security. When such signs are noted, he should calmly make a personal inventory to learn, if possible, whether any correctible faults are to be found in his manner of administering the hospital. A frank conference with the president of the board sometimes serves to clear the atmosphere. If, however, the continuance of his term of service must be bought by a relinquishment of ideals or a lessening of vigilance in the interest of the sick, the superintendent should decide to move on to other fields of endeavor. If pettiness and ethical dishonesty are demanded professional happiness and efficiency will surely lie elsewhere.

The man or woman engaged in hospital work who serves but one master — the hospital patient — and who tactfully endeavors to point the way of service to others need have little fear of his administrative future.

One Business of the Board

HOSPITAL boards constitute the balance wheels that maintain the steady and consistent development of sound institutional policies. They should deal with large matters of community relationship, the procurement of endowments and the development of the highest type of medical service.

Occasionally board members are misled into considering their function as being largely concerned with attention to administrative details. Such an attitude is demoralizing and represents an expensive type of administration. To develop a fund of information relative to the aims and accomplishment of the hospital in the minds of wealthy and philanthropically inclined individuals is certainly an important business of each board member. Large institutional bequests rarely represent sudden inspirations on the part of the wealthy. They come only after well considered contemplation of effective measures for serving a community. Hospital board members are useful agents in creating the will to give.

Such contacts with those of means represent a more potent method of serving the sick than rounds of inspection or the supervision of the work of the superintendent's office. There are vast community resources both physical and moral yet to be tapped. When and how this is to be done is the chief business of the board of trustees.

How the Hospital Can Improve Its Obstetric Work*

The medical profession as never before is being held to account for every maternal and infant death. This is a healthy condition and will without doubt improve maternity services

FOR many decades the public has appeared satisfied with the work of the maternity departments of general hospitals and with similar service rendered by special institutions. It has taken for granted that since pregnancy and delivery are states fraught with danger for mother and child a certain morbidity and mortality are to be expected. Lay persons generally, however, have not been able to ascertain facts concerning the prevention of obstetric accidents, and hence have been in no position to form a true idea of the efficiency of maternity services.

Approximately a year ago there was made public a report of the public relations committee of the Academy of Physicians of New York on maternity mortality. Later a similar report emanated from the Philadelphia county medical society maternal mortality committee. In addition other attempts have been made to ascertain the true state of affairs regarding the obstetric work of hospitals and also of physicians and midwives practicing in homes. As a result, the public is thoroughly aroused about this matter.

Individuals and scientific societies originating these reports deserve credit for having called the attention of the medical profession to its shortcomings. The American College of Surgeons deserves its full meed of credit for having a number of years ago laid down minimum requirements for the organization and conduct of the obstetric department of the general hospital. Nevertheless it required the prosecution in large urban communities of extensive surveys and the development of comparative statements as to local maternal morbidity and mortality statistics and those of other states and cities in order to bring about any strong practical move to correct the errors in technique and organization which existed.

Generally these studies concluded that the maternal death rate was far too high and that many of these accidents were preventable. It was repeatedly pointed out that the fault did not lie at the door of the doctor alone but that patients themselves and also hospitals must bear a share of the blame. An idea as to the part the hospital plays in maternity work can be gained from the fact that in 1934 there were 48,048 births in special maternity hospitals and 648,995 in general hospitals.

A startling statement appeared in more than one of the reports mentioned indicating that the percentage of home deaths was less than that of hospital deaths. The public was quick to conclude that the hospital offered less safety to the pregnant woman during her delivery than did the home. This statement, however, must not be taken at face value. Many writers have pointed out that home deliveries largely consist of those in which the patient has been in labor but a short time or of those in which the greatest degree of normalcy exists and in which few examinations and no major manipulations are necessary. Other generalizations appeared in these reports which were somewhat misleading to the public and which require study and interpretation before they can be fully accepted.

Since the hospital plays a large part in obstetric work it should present a highly specialized personnel and technique. Every endeavor should be put forth to render as safe as is possible the treatment of both mother and baby. The superintendent of the hospital, particularly if he is not medically trained, is inclined to feel somewhat ill at ease in the maternity department. There exists there a certain atmosphere of exclusiveness that discourages visiting. Hence some superintendents do not conduct careful physical rounds in the maternity department because they do not desire to embarrass patients, nurses or doctors by their presence.

This is a mistake. In this department, if anywhere, is needed the best housekeeping, the most sanitary provisions. Unless the superintendent assumes active personal responsibility for the physical perfection of the department, it is likely to fall far short of the ideal. Too often physical

*Practical Administrative Problems Series.

inspection is left to the nurse who is in charge.

It is a far cry from the early days of the old Pennsylvania and Philadelphia General Hospitals when strong opposition arose in regard to the establishment of a maternity department because it was supposed that such a move would be inclined to increase immorality among the population. To avoid such a calamity special rules and regulations were adopted which required that only respectable married women be admitted to these obstetric wards. Such a provision today would of course appear ludicrous and no institution worthy of the name refuses medical care to a needy one or confuses the presence of such a need with the absence of high moral virtues.

It is equally difficult to believe that in those early days it was not considered a breach of technique to hold obstetric clinics in quarters used for other purposes, such as the performance of infected surgery or even postmortems. The causes of puerperal sepsis were then not even suspected.

Doctors and Nurses Must Be Letter Perfect

Now physicians are fully convinced that death lurks in the least slip of a perfect technique, that nurses and doctors must be letter perfect in all that they do for the maternity patient. The best of equipment is of little avail unless nurses are well trained, residents continually supervised and the visiting staff meticulously careful. The lay person often wonders why the pregnant woman is so prone to infection. The public little realizes the bacteriologic principles involved and hence is not surprised at careless obstetric practices in the home. To be sure, the members of a family to which several children have been born expect to provide sterilizing facilities for gloves and instruments but they cannot be informed concerning the danger of numerous examinations or the harmful potentialities of long delayed labors.

There are certain basic principles which must apply in the construction of the maternity department of a general hospital. These are almost too well known to warrant reviewing, and yet a few might properly be set down here. Complete separation of the physical properties of such a department from the rest of the hospital is essential. No common sterilizing plant should be condoned nor should the delivery room and the operating suite have anything in common. Of course, the wider the separation of maternity patients from others being treated for medical or surgical conditions the better. The preparation of a specialized technique book of rules for the maternity department is a basic necessity and no plan for time sharing in the nursing force should be permitted.

The separate or special maternity hospital has some advantages over the maternity department of a general hospital. Here the whole business of the institution concerns itself with the treatment of pregnant women and the newborn. There can be but little doubt that such focusing of attention on one activity is likely to lead to the greatest efficiency, and yet with the proper understanding of the importance of maternity work a general hospital group may reach a high degree of effectiveness, under favorable circumstances.

The superintendent visiting the maternity department may be somewhat surprised to find unoccupied rooms and ward beds. As he studies occupancy sheets in his office, he may wonder what fault of the hospital or of the staff is responsible for these empty beds. It might be wise to interject here a few practical financial considerations. Many maternity hospitals confronted with a falling birth rate in their communities have found it necessary to reorganize both the maternity service offered and the corresponding rate card. They have found that, whereas in other days a prospective father did not hesitate to spend several hundred dollars during the confinement of his wife, he now finds this impossible. Private rooms in the upper economic brackets remain empty and, home deliveries increasing in number, the utilization of even the cheaper private rooms and semiprivate and ward beds is lessened.

Lowered Rates Prove Satisfactory

Because of the apparent need for adjusting hospital rates for maternity service downward, not a few institutions have enlarged their semiprivate facilities and have offered flat rates covering a ten-day or a two-week hospitalization in this department. The current rate in not a few localities appears to vary from $45 to $55 for a ten-day stay in wards housing from two to four patients respectively. This charge covers not only room fees but also all others, including delivery room and medicine charges as well as the care of the baby. Private room rates have also been scaled downward in many localities to begin at approximately $6 a day and to range not as high as was formerly the case.

Such a readjustment has proved satisfactory and has enabled many hospitals to maintain a nursing force capable of caring for a large number of patients at little added expense to the hospital for overhead. The flat rate system appeals particularly to the young father and expectant mother because it facilitates budgeting and renders the advent of the first-born less financially embarrassing.

Some disadvantages, however, have been en-

countered in organizing this semiprivate system. It is improper to place a woman, even in early labor, in the same ward with others who have been delivered. The unavoidable disturbance of rest and sleep thus produced is not likely to render such a ward popular. Of course, there should be labor rooms for those in whom delivery is imminent or who present some complication.

No provision for maternity patients can be complete without careful attention being given to the nursing methods. In some hospitals twenty-four-hour nursing duty is frowned upon. Perhaps in the maternity department it is more often permitted than in any other. In the first few hours following delivery, active nursing care of the mother may be necessary but as time goes by, the attention of the nurse is likely to be given largely to the infant. Many women engage a nurse more because they desire to guarantee that the baby is well cared for than because they themselves require her services.

A Nursing Problem

This leads to the question of whether the nursery should be in charge of pupil and floor nurses or whether the infants of private patients should be cared for there by special duty nurses. The care of the newborn infant is a highly specialized activity. It is claimed by some directresses of nursing schools that they are able to maintain a better technique when pupil nurses are assigned to this ward than when an ever changing group of special nurses are permitted there. There is probably some truth in this statement.

On the other hand, some highgrade hospitals have provided special nurseries for the reception of the infants of private patients in which their care is left wholly to special duty nurses. Private patients are more content with the latter arrangement. They see no reason why their infants should be turned over to a nurse other than the one whom they have engaged. There are good reasons for this attitude. It is probably better, therefore, when physical facilities are at hand to allow special duty nurses to care for the infants of their patients and for ward babies to be assigned to pupil and general duty nurses.

Some interesting practical considerations arise at this point. Some hospitals provide baby necklaces at the expense of the mother. Others believe that the outlay for identification markings should be borne by the hospital. Some institutions realize a considerable sum from the sale of baby birth certificates. Others believe this practice undignified and either present such a document with the compliments of the hospital or give none.

Interesting possibilities for publicity suggest themselves in this connection. The sending of birthday greeting cards to children born in the hospital is pleasing to the parents. Such a practice requires a slight outlay of funds and time and is a continual reminder to the hospital's clientele that its interest in children born within its walls does not cease upon their discharge from the hospital. Other institutions maintain a continuing interest in the maternity department by each year holding a baby contest. This has many interesting possibilities but since all babies cannot be given prizes there is to be considered the danger incident to hurt feelings and maternal disappointments.

The superintendent of a hospital might well know more than is usually the case about the scientific work of this department so that he may be able to interpret the efficiency of its activities and of its staff. While it must be taken for granted that every delivery is dangerous both to mother and child, yet these dangers can be greatly minimized. In the mortality report of the New York College of Physicians, it was stated that of the total deaths studied, in 61 per cent, 37 per cent and 2 per cent respectively, doctors, patients and midwives were in some measure at fault. These figures were computed upon the total number of patients handled by these groups and it appears that it was by this method of computation that the truth was distorted regarding the relative safety of home and hospital deliveries. If the total number of cases handled by each group were considered and percentages computed thereon, 47 per cent and 60 per cent respectively of these preventable deaths were attended by doctors and midwives. This is true because the latter handled but 8 per cent and the former treated 91 per cent of the total number of patients in this group.

Discretion Is Called for

The superintendent's attention should also be drawn to the fact that it is not always to the credit of his hospital to have performed therein a large number of operative deliveries. It is true that complicated operative procedures are often life-saving when in good hands but when unskilled physicians endeavor to carry out some of these practices, infant and maternal mortality rises.

It should interest even the lay superintendent to know that approximately two out of every hundred deliveries are made by the cesarean route while in certain of the studies mentioned above this operation led to about 20 per cent of the deaths. In scanning the report of the maternity department, therefore, the executive might well compute the percentage of cesarean sections and when these deliveries rise higher than approxi-

mately one out of fifty or sixty, inquiry should be made as to the reason therefor. Sometimes obstetricians are inclined to favor a shorter and more spectacular section than patiently to endeavor to deliver in the usual fashion. The administrator may well ask himself how the number of operative procedures performed in his institution compares with those in other hospitals and how these methods affected the chance of the mother and the child to survive.

Attention might also be directed to the methods by which morbidity statistics are compiled. A number of standards exist which are employed to determine when a patient may be classed as morbid. In one a temperature of 100.5° occurring on two successive days or twice on the same day after a period of twenty-four hours has elapsed following delivery places the patient in the morbid class. Whatever the system in vogue, a careful search for the cause of fever following delivery should be made and none of the time-worn excuses should be accepted. Such a fever should never be lightly considered as a natural aftermath of childbirth. The zeal with which such matters are studied and reported is a fair criterion of the efficiency of an obstetric staff.

The average superintendent should be interested in the minutes of the obstetric staff conference, which should reflect an interest in the perfection of records, in the investigation of each maternal death and in the thoroughness with which the observance of a specialized technique is required. If there is a tendency to spare the feelings of the members of the staff at the expense of the obstetric patient, the hospital might well be considered as an unsafe place for these women.

Doctor Should Be Questioned in Fatal Cases

It is a healthy practice to require of the physician in charge full explanation when one of his patients, be it mother or infant, dies. It is beneficial also to ascertain whether interns are permitted to deliver routinely all ward cases or whether they are carefully supervised and instructed. The use of forceps and the performance of extensive repair work by the intern in the absence of the chief should be forbidden.

Courtesy staffs are inclined at times to rely upon interns to deliver patients in whom some major or minor complication has arisen. This practice should be definitely forbidden. A courtesy staff member has no right to possess such privileges unless he is competent to perform the usual obstetric procedures.

The attitude of the staff toward the education of nurses and interns should also be a matter of interest to the superintendent. Generally the maternity nursery is in charge of the staff pediatrician. The superintendent might learn concerning the regularity of visits paid and the nature of the examinations made. Too often the newborn are considered normal patients possessing little clinical interest. Their charts often reflect this careless attitude. The newborn deserve the most careful attention. Physical examinations cannot be too complete and recorded bodily measurements are of much importance. In many institutions where Jewish patients are accepted there exists a more or less officially appointed cleric who is responsible for the performance of religious circumcisions. The superintendent might well learn concerning the degree of staff supervision over this type of work. Are these operations carried out in a surgical, cleanly manner or are instruments and dressings carelessly handled?

Requirements for the Department

The minimum requirements for a maternity department, as set forth by the American College of Surgeons, include basic necessities beyond which the hospital may well go for the benefit of the patient. Nevertheless they serve as a useful framework to govern the organization and conduct of this department. They are as follows:

1. Segregation of obstetric patients from all others in the institution.
2. Special facilities for immediate segregation and isolation of all cases of infection, fever or other conditions inimical to the safety and welfare of patients.
3. Adequately trained personnel, the entire nursing staff to be chosen specially for work in this department and not permitted to attend other cases while on obstetric service.
4. Readily available adequate laboratory and special treatment facilities under competent supervision.
5. Accurate and complete clinical records.
6. Frequent consultations encouraged on obstetric service. A consultation may be obligatory in all cases where major operative procedures may be indicated.
7. Thorough analysis and review of all clinical work of the department each month by the staff, with particular consideration of deaths, infections, complications or unsatisfactory conditions.
8. Adequate theoretical instruction and practical experience for student nurses in prenatal, parturient and postpartum care of the patient as well as care of the newborn.

In a succeeding article will be discussed matters of interest to the superintendent relative to the conduct of prenatal, postnatal and well baby clinics.

PLANT OPERATION • • • •

Conducted by John C. Dinsmore and R. C. Buerki, M.D.

The Art of Sharpening Scalpels

By George G. Little, M.E.

Superintendent, Instrument Shop, Mayo Clinic, Rochester, Minn.

THE art of sharpening edged tools is governed by the principle of bringing two plane surfaces together at a predetermined angle, to form a line known as a cutting edge. The cutting edge of the usual type of scalpel is curved. The material it severs requires a keen, sharp edge, one that ensures leaving clean, smooth surfaces that will heal quickly when united.

Keenness is produced by reducing the cutting edge to a thinness limited by the strength of the metal required to keep it from breaking out or nicking too easily. Sharpness is produced by beveling the cutting edge at an angle most suitable for the purpose. For scalpels, this angle on both sides of the blade should not exceed 20 degrees, included between the center of the blade and the surface of the oilstone. Time and patience are required in perfecting the ability to sharpen scalpels. A knife may have a true straight cutting edge or one that is curved, the shape in no way affecting the principle governing the art of sharpening.

Practically all scalpel edges are easily sharpened on a true flat abrasive surface, the sharpening angle and the thinness of the edge are determined by the nature of the material to be severed. The material to be severed and the type of knife determine the kind and grade of abrasive stone most suitable for the purpose.

The shape of the blade of the scalpel gives efficiency to its use. Therefore it is important that its shape, in proportion, be maintained throughout its usefulness. This may be done by proper reduction of its thickness, to conform with the wearing away of the cutting edge toward the back of the blade. The blade may be properly reduced in thickness and at the same time its proportionate size, with the important concavity of its sides may be maintained by grinding on the radial face of a circular oilstone of medium grade.

The proper thinness of a cutting edge varies with the size of the blade, from 15/10,000 inch to 3/1,000 inch or 4/1,000 inch (4/100 to 1/10 mm.).

The removal of metal by grinding creates heat through speed and friction, which will, when not prevented, destroy the temper of the cutting edge as it is being reduced in thickness. To avoid this, the blade should be kept covered with a constant stream of coolant during this operation. There are several kinds of coolants, but it has been found best when many knives are being sharpened to use gasoline on both the motor driven circular stone and on the hand sharpening stones. Any light oil will answer the purpose. Oil, however, leaves an undesirable film on the blades and gets over everything else on the sharpening bench, unless constant care is given to keeping things clean. Gasoline does not do this and does answer the purpose of cooling the work and keeping the abrasive surfaces clean and free cutting.

There are three oilstones essential to proper equipment for sharpening scalpels and the heavier knives of the laboratory. (Figs. 1 and 2.) The abrasive stones, found by years of constant usage to be the most suitable for sharpening scalpels, are the Norton Pike India oilstone and the hard Arkansas oilstone. These two abrasives are sufficiently hard in texture to retain their true working surfaces under long and hard usage when properly cared for.

One of the chief advantages of the Norton Pike India stone is the absolute uniformity of the coarseness or fineness of the crystals. A second advantage is the unvarying hardness and texture throughout the stone, precluding any possibility of hard and soft spots in the abrasive surfaces. They hold their shape indefinitely. There is no steel too hard for them to sharpen quickly, and none hard enough to cause them to wear down unevenly if properly used.

This stone is used in reducing the cutting edges by hand movement. The blade is held flat and the cutting edge is given slightly more pressure than in the back of the blade. The blade is moved from right to left, with the edge as shown in Fig. 2; the blade is reversed at the beginning of the return stroke, left to right. Use of this stone for this purpose will result in the blade becoming too thick for its width to be given keen sharpness and the sides will become and will remain straight until reground on a circular stone. It is necessary to elevate the handle slightly as the stroke is given, to bring the curved or tapering point of the blade in contact with the oilstone.

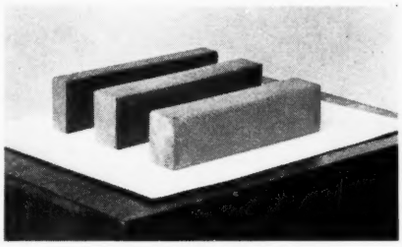


Fig. 1

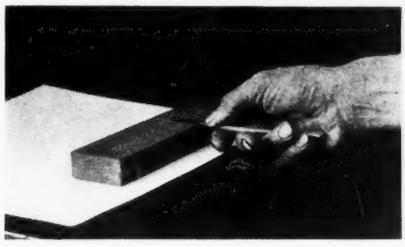


Fig. 2

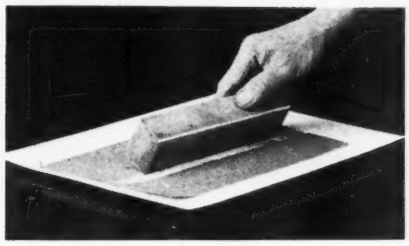


Fig. 3

The hard Arkansas oilstone is a natural sharpening stone that no other natural or artificial stone approaches for its particular purpose of sharpening tools requiring the finest edges, such as are used by surgeons, engravers, dentists and many others. It is sixteen times harder than marble, has a finer grit than any other oilstone and imparts the smoothest edge. The Norton Pike India stone is artificial and is oil filled by a process that gives it remarkable freedom from glazing. This makes the stone ready for use with only a slight application of oil, and avoids the necessity of soaking it in oil for days before it can be used. The Arkansas stones must be soaked for three or four days in a light oil to prepare them suitably for use. The soft Arkansas oilstone is used more for the edges of larger and less keen laboratory knives.

There are three objects to be attained in taking good care of an oilstone: first, to retain the original life and sharpness of its grit; second, to keep its surface flat and even; third, to prevent its glazing.

To retain its original freshness, it should be kept clean and moist and never left to dry over a long period. To keep the surface flat and even simply requires care in using by moving the tool, as it is being sharpened, over all the surface and not over a small, restricted spot. To restore an even, flat surface, the stone should be rubbed over a sheet of medium coarse emery cloth supported on a firm, true surface. (Fig. 3). The stone should be rubbed first lengthwise, then crosswise over the cloth. The cloth may be cleared of the accumulating stone dust by sudden shaking. To prevent a stone from glazing requires merely the proper use of light oil. Edges of scalpels do not require stropping after sharpening.

This method of truing up the edges of the hard Arkansas stone, and giving them a radius of about 1 mm. removes all nicks and prevents further irregularity of the edges that would cause injury to the cutting edge of the knife as it is being sharpened. The edge of the stone is rubbed lengthwise over a sheet of emery cloth, supported on any true flat surface. A rolling movement given the stone forms the required radius. This operation is done entirely dry, as is shown by the surface of the cloth and the accumulated stone dust. Fig. 3.

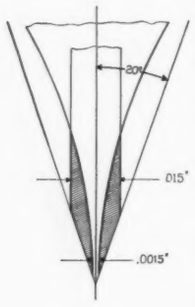


Fig. 4

The resistance to wear, of the hard Arkansas natural stone when properly used and cared for, is realized when it is known that the stone illustrated was in constant daily use and sharpened thousands of scalpels throughout a period of more than twelve years and has lost little more than half its original thickness.

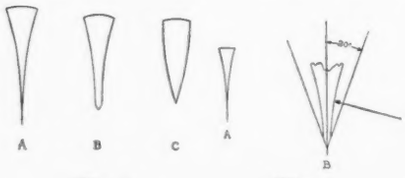


Fig. 5 *Fig. 6*

While this article has to do primarily with the sharpening of the one-piece standard scalpel, the principle involved and much of the information imparted are applicable to the sharpening of detachable blades, although the technique is somewhat different because those blades are made of thin, flat steel with cutting edges of greater angle and thickness, making it difficult to impart the desirable keenness to their sharpness.

The shapes of these blades and their handles, or of any adapters, prevent hollow grinding to give them keenness and make them more difficult to hold for hand sharpening. Fig. 4, a cross section of a blade of standard scalpel (concave) and of a detachable blade (shaded), shows a comparative view of the thickness of the blades, thus explaining why the blade of the standard scalpel can be given keenness added to its sharpness and why the flat-sided, detachable blade does not have that keenness. Both are sharpened at the same angle, yet the curved sides of the standard blade permit it to enter more deeply and more freely, while the detachable blade will not enter so deeply or so freely.

The comparative thinness of the cutting edge of the standard scalpel is also presented in Fig. 4, which shows the concave sides of the blade converging to a parallel thinness of 15/10,000 inch, one-and-a-half thousandths of an inch, forming an edge that is easily and quickly given the required keen sharpness at the 20-degree angle, while the detachable blade, with the parallel sides forming a thickness of .015 inch, fifteen thousandths of an inch, ten times the thickness of the standard cutting edge, although given the same angle of cutting edge, cannot be made to take the keen sharpness of the thinner edge.

A cross section of the blade of the standard scalpel in Fig. 5 A, is of the original shape when new. As the blade is resharpened it becomes thicker at the cutting edge (Fig. 5 B) and when the sharpening is continued on the flat

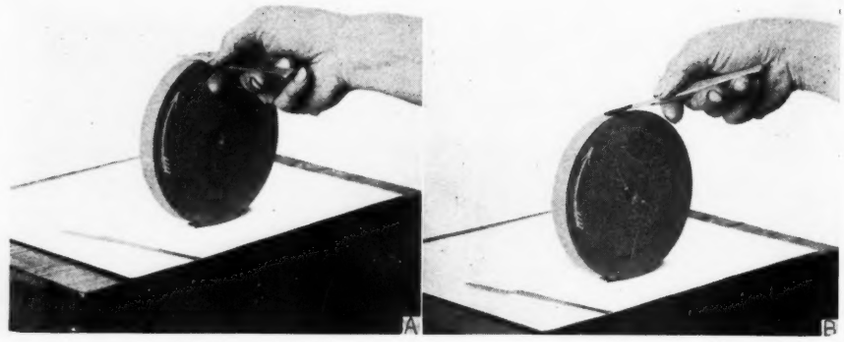


Fig. 8

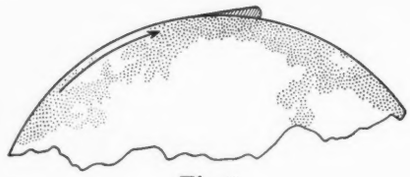


Fig. 7

oilstones, without the blade being reground to retain the concave sides, the thinness necessary in producing a keen, sharp edge is lacking, causing the blade to assume a shape similar to that shown in Fig. 5 C; this type of blade can be made sharp enough to cut only with added pressure.

The concave sides (Fig. 6 A) are formed by grinding on the face of a circular oilstone. Fig 6 B is an enlarged diagram of the concave sides, showing them to be nearly parallel a short distance back of the cutting edge. The cutting edge is 20 degrees and the arrow represents the radius of the circular oilstone.

Fig. 7 shows the position of the

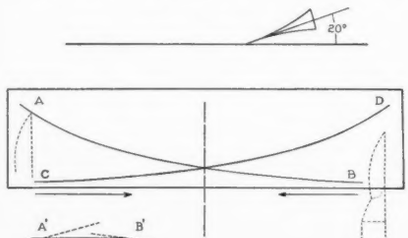


Fig. 9

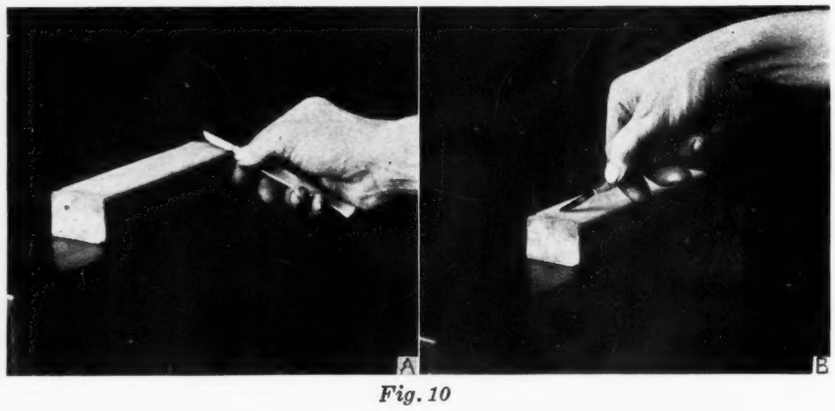


Fig. 10

blade on the face of the circular stone as the blade is being reduced in thickness to retain its proportionate shape. The stone rotates against the cutting edge; thus, formation of a wire edge, with possible breaking out of the metal back of the actual cutting edge, is prevented.

Fig. 8 A and B illustrates further the use of the circular stone. In the use of a circular oilstone for reducing the thickness of the cutting edges the blade is placed flat against the circular face of the stone and the handle is elevated slightly as the point is

Fig. 11

brought in contact with the surface. By putting as much pressure on the back of the blade it may be ground evenly and the proportional shape of the blade maintained. A shows the beginning and B, the finish of the movement. The other side of the blade may be ground with the edge pointing with the rotation of the stone instead of against it, as shown, or with the edge against the rotation by holding the handle on the other side of the stone, a difficult task for some sharpeners. It is necessary to be able to hold the blade in a steady position to ensure a true finished surface on both sides of the blade and an even, curved edge, without overgrinding (cutting the edge away).

The lines AB and CD in Fig. 9 represent imaginary lines, or if preferred, black pencil lines, on the face of the flat sharpening stone arranged as a guide to the movement of the cutting edge as it is passed over the surface of the stone. The movement is as if an effort were being made to remove the lines by scraping them off with the cutting edge, having the heel start at B and the movement end with the point of the blade at A.

The scalpel should be held, during the movement from B to A and from C to D, at a right angle (90 degrees) to the sharpening stone, as is shown by the broken outlines (Fig. 9). The heel of the cutting edge rests on the rounded edge of the stone at the angle B′. (See diagram in lower left corner of Fig. 9.) The back of the blade is raised to the 20-degree angle and the hand is gradually raised during the movement to the angle A′, to attain the position at A, with the point resting on the stone. Thus, the entire edge of the blade has been made to touch the abrasive surface of the sharpening stone, on the right side of the blade.

The knife is then raised off the stone enough to clear the surface, is rotated to the left, cutting edge down, to a 20-degree angle, and, starting at C, with the blade in the same position as at B, it is put through the corresponding movement to the right (from C to D) to sharpen the left side of the blade.

The movement is shown photographically in Fig. 10 A and B. In A, the scalpel is held, handle lowered slightly to bring the heel of the blade in contact with the rounded edge of the sharpening stone. (See B′ and A′, Fig. 9). It is held against the stone at the 20-degree angle for sharpening and is rocked on its curved, cutting edge as it is brought from right to left, thus ensuring the entire edge touching the surface of the stone as it reaches the point shown in Fig. 9 B. The thumb and index finger grip the handle to keep it in proper position while the ring and little fingers form a pocket for the handle to rotate in, ready for the return stroke from left to right for sharpening the other side of the blade. Fig. 10 A represents B in Fig. 9, while Fig. 10 B represents A in Fig. 9.

How to Hold the Knife

The sharpener's position should be such as to permit a free swing of the forearm, with the elbow centrally placed in front of the stone at a level with its sharpening surface. In this position the knife can be given the proper movement over the sharpening surface while it is being held correctly for both the right and left movements.

A new blade should be sharpened with care and not ground until the cutting edge becomes too thick to be made keen. The first few grindings must be done carefully to avoid overgrinding and mutilating the true shape of the cutting edge. The amount of grinding necessary depends on how long the knife has been used and how many times it has been sharpened between grindings. When the knives are in daily use, they should be sharpened lightly between surgical operations to ensure edges without dull spots and nicks to annoy the surgeon. Knives should be reground after four to six surgical operations. However, if nicks have been made in them, of course grinding of the cutting edge is required to remove them.

The fine steel blades of standard scalpels cannot be improved on for efficient service and economy in use. They will take and retain a keener sharpness than any other, are easily kept clean and give steadiness and assurance that they will sever the tissues quickly with the slightest of pressure and will leave smooth, clean surfaces for rapid healing. The method of testing the cutting edge is shown in Fig. 11. In testing the keenness of the sharpened scalpel, a strip of thin, soft leather is used. The cutting edge is drawn lightly against the folded leather with a very short stroke, just enough to get the feel of the keen, smooth sharpness. Cutting just under the surface is sufficient. Any deep cutting is useless, and really tends to start the dulling of the edge without telling more than the slight, short shallow cut. It will be noted that the knife is being held as in the sharpening process, which shows this position to be a natural one with which to get the best results. Leather for this purpose should be thin and soft and the smooth or hair side used. Shoe uppers are suitable and scraps of this leather can be obtained from shoe factories.

Efficient economy in the use of the standard scalpel is undeniable when it is known that for eleven large busy operating rooms, it is necessary to purchase only four or five dozen replacement scalpels a year. Eight of twelve scalpels, placed in service in 1920, have been and are still in daily use, and show little more than 10 per cent reduction in the size of their blades. While this is probably exceptional it is believed that there are older scalpels still in service in the hospital from which the foregoing statistics were derived.

There are many ways in which the cutting edges of scalpels may become damaged. The greatest of care should be exercised in the handling of these fine instruments, to ensure having them reach the operating table in first-class condition. The cutting edge should never be permitted to touch anything from the moment the sharpener places it in the carrying case until it is received by the surgeon at the operating table.

Soundless Light Switches

The slight noise made when an electric light switch is snapped on makes but little impression in a business office. To the seriously ill patient on the hospital floor however, or to anyone on the hospital floor at midnight, the light switch may sound like a pistol shot. In order to avoid these slight noises the typical hospital floor at night will burn more lights than are needed.

The superintendent of one of the Midwestern hospitals has removed that one more disturbance of hospital peace by changing all the switches on the private floors to the new type mercury arc switch which is entirely soundless. This type of switch has the added feature of being sparkless so that it may safely be operated even in the presence of inflammable gases.

As soon as possible this same hospital superintendent hopes to install the soundless sparkless mercury arc switch on every floor occupied by patients.

How One Hospital Solved the Incinerator Problem

FAIRMONT HOSPITAL, San Leandro, Calif., required an incinerator that would handle a large amount of refuse, including heavy wet garbage, large casts and other material difficult to destroy. Cost of installation and operation were given careful consideration and the incinerator illustrated here was built to meet all of these requirements. A gas connection is provided but has not been needed.

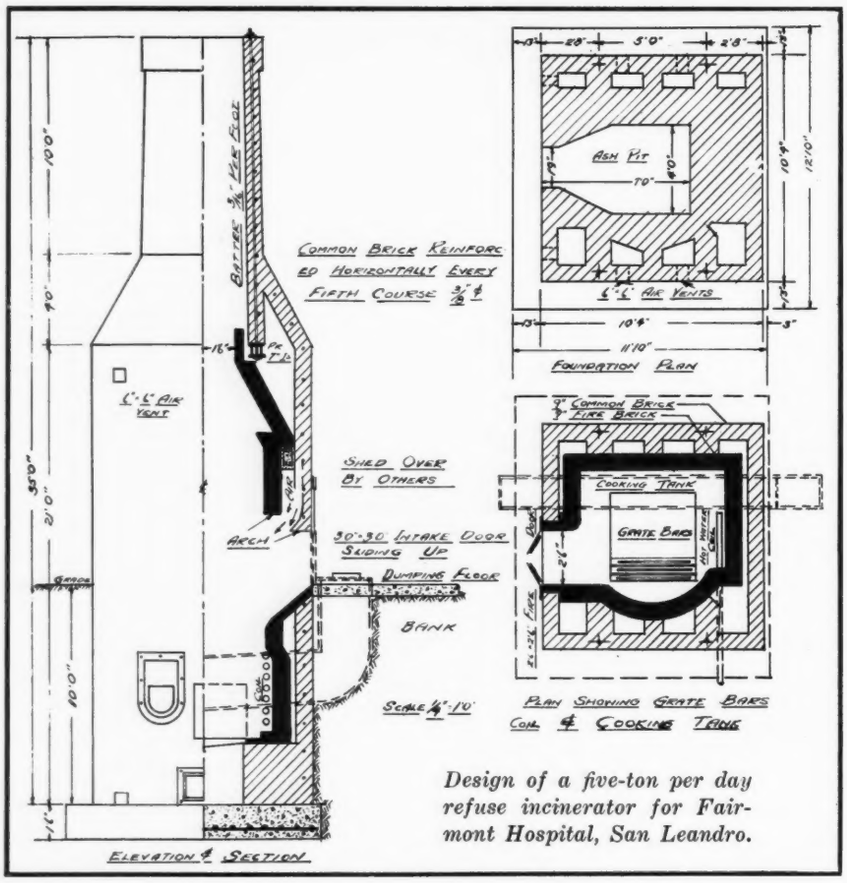
In addition to incinerator problems common in all large hospitals, Fairmont had the problem of cooking swill from the tuberculosis wards to make it desirable for hog feed, as a farm is operated in connection with the hospital. It was felt that the garbage to be burned should be used to cook this swill and to heat water for washing cans. A steel tank was designed and installed at one side of the fire box in such a way that the swill could be poured in at the dumping floor and drawn off at the other end. A large hot water coil was also installed.

The incinerator is so constructed that if the brick in the fire box should burn out it can be cheaply and quickly replaced. Air vents were installed so that the capacity could be greatly increased by the installation of forced draft, if required.

The location selected was on a side hill. An unloading platform and a room providing for storage, dumping floor and can washing were constructed on the upper side with the floor 10 feet above the bottom of the incinerator.

The entire unit was built as a state emergency relief administration project at a nominal cost. The construction was closely supervised and directed by the designer.

It has been in operation for about three months and is giving satisfactory service. A. C. Jensen is superintendent of the Fairmont Hospital.



Design of a five-ton per day refuse incinerator for Fairmont Hospital, San Leandro.

Paper *Versus* Cloth Towels

A study was made at the University Hospitals, Cleveland, on the cost of paper *versus* cloth towels on four divisions and one personnel washroom.

According to Worth L. Howard, assistant director of the hospitals, the paper towel consumption for a one-month period on these divisions was 51,500, while the cloth towel consumption for a similar period was 49,500, or 2,000 less. From previous studies made covering the same locations, it was found that there was a variance of approximately this number of towels when only paper towels were used. Therefore the difference of 2,000 towels was not used in figuring this cost comparison.

While some people use two paper towels for drying hands where they would use but one of cloth, they appear not to use them so much for drying the face, polishing shoes or other miscellaneous purposes. Also a sign on the paper towel cabinet reading "Why use two when one wipes dry?" seems to have been effective.

The cloth towels used in making this study were specially marked and at the end of the test period an inventory was taken. It was found that there was a loss of 5.7 per cent.

The materials from which these towels were made cost thirteen cents a yard, four towels being made from one yard of material, and the manufacturing cost was $1.05 a hundred. From actual washing tests, the material stood 160 washings.

A price was obtained from a commercial towel supply house, as quoted in the figures below. This cost is considerably higher than either of the hospital's costs and to the figure must be added the cost of replacing a dirty roll with a clean one, which would probably require a full-time person.

There follows a comparison of the cost per use of these three methods of supplying towels:

Rental Roller Towels	$0.00180
Cloth Towels (Hospital Owned)	
Material manufacturing cost per use	$0.00027
Laundry cost per use	0.00050
Folding cost per use	0.00025
Loss cost per use	0.00024
	0.00126
Paper Towels—Cost per towel	0.00088
Additional cost per towel of hospital owned cloth over paper	0.00038

In 1934 the paper towel consumption was approximately 3,900,000 towels. If the above figures are correct, and it is believed they are, there would be an additional cost of $0.00038 in the cost per use of the cloth towel over the paper towel, or an annual additional cost of $1,482. The rental towel would cost $3,588 more.

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Clinical results in many hundred hospitals have definitely proved that the daily use of the Oil keeps the baby's skin in better condition, and increases its defenses against infection.

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Conducted by Anna E. Boller, Rush Medical College

A Hospital Dietitian Reviews Progress in Her Field

By Mary M. Harrington

Director of Dietetics, Harper Hospital, Detroit

A DECADE ago the late Dr. E. S. Gilmore[1] speaking before the American Hospital Association, placed the dietetic department beside the hospital laboratories and relegated the financial and administrative duties to the less technically trained steward; no mention was made of any educational responsibility. At that time a plea was made to the dietitian to prove her value to the physician, the patient, the hospital. Evidence showed that the dietitian had not found her place in the hospital field.

The college had a different idea of the function of the dietitian and Morgan[2] considered this worker as dealing more with the medical than with the administrative and nursing ends of the hospital. Morgan also urged that hospital training for the dietitian be limited to a few hospitals which could meet high standards of service and equipment, and that these schools be graded by competent inspection. However, it was predicted that the standards could be met by only a few hospitals and leaders within the next twenty-five years.

Standards Have Been Raised

Developments during the last decade have defied these predictions. Higher standards are now required and recognition is given by hospital administrators to the improvement in the department. The appreciation of the need of higher standards is shown by the requirements suggested by the American Hospital Association[3] the American College of Surgeons,[4] the American Medical Association,[5] and the United States Civil Service. Keller,[6] speaking before the American Hospital Association, expressed the hospital administrator's viewpoint in the following statement:

"It appears to me that the higher dietary standards that have resulted in recent years have been due largely to the efforts of the national, state and regional dietetic associations. These efforts should receive the full cooperation and support of the national and local hospital associations, and both groups should develop interlocking committees for the consideration of their common problems."

The American Dietetic Association[7] has been earnestly engaged in raising the standards of the profession and now admits to its membership only candidates who possess a bachelor's degree from a recognized college or university with a major in foods and nutrition or institution management. The hospital dietitian follows this academic preparation with a hospital training course approved by the American Dietetic Association for the period of nine months to a year. This training gives an opportunity to test vocational skill and social attitudes under the guidance of competent dietitians.

Quality Not Quantity Counts

The trend in these courses is toward concentration on the quality of students trained and the quality of courses rather than quantity. In 1927, Thallman[8] reported a survey of seventy such courses. These were mostly confined to single institutions and varied in length from three months to one year. Fifty per cent were six months in length, only three of the hospitals requiring nine months. The rank of these students in the institution varied from the equivalent of a student nurse's rating to that of a staff membership with some classed as "professional" help and some considered only as students. This survey showed an emphasis on the administrative and therapeutic functions of the dietitian.

Koehne[9] summarized the results of the inspection for the year 1934 and reports fifty-five approved courses. These hospitals employ a total staff of 305 dietitians and are training 377 dietitians a year.

Only five of the larger hospitals limit the training to their own institutions. However, in this group of forty-nine hospitals, affiliations with other institutions range as follows: with one other institution in eight hospitals; two in eighteen hospitals; three in thirteen hospitals; five in four hospitals, and more than five affiliations in two hospitals. The amount of time spent in the parent training course ranges from one year in institutions without affiliations to as short a period as five months in courses that have several affiliations.

Bryan,[10] in 1934, appraised the progress made in the training of the student dietitian and emphasized her belief that courses for student dietitians should never become standardized. Affiliations as a means of broadening the experiences of the student and increasing the number of masters responsible for a training course were new developments. Affiliations with clinics and public health agencies were listed as essential in the training. Bryan states, "The hospital is but one link in the chain of the community health and its program must tie in closely with that of other community agencies." Affiliations in public and private hospitals, large and small hospitals are offered presumably with the aim of developing students better prepared to serve in any type of hospital.

A. D. A. Lends Its Aid

The American Dietetic Association realized that improvement in practices would promote improvement in standards and by utilizing the instrument of enforcement has been able to maintain an increasing activity program to be offered to students in approved courses. There is a uniform agreement of the profession that periodical inspections do maintain an improvement in current practices and promote standardization. However, all professional fields admit wide differences of opinions on values and methods of standardization. The contributions of individual institutions which have unique opportunities must not be sacrificed to meet standardization in some of the minor practices.

Haggerty,[11] in discussing standardization of institutions of higher education, states, "The individuality and differential purposes of an institution are precious assets in our social economy, and they must be protected by any accrediting agency that would not do violence to public welfare. We would not make individuals alike; neither may we coerce educational institutions into a single mold. It is not unvarying conformity to a single pattern that we seek; it is effective institutional service to the widely varying abilities and interests of the young people who seek, through higher education, a meaningful preparation for the kind of life they desire."

Sometime ago, the chairman of the professional education section of the American Dietetic Association raised the question, "What should be the trend of student dietitian training in the hospital?" The scope of the profession according to an analysis by

the vocational group clearly shows that persons trained in dietetics apply their knowledge to food preparation and service, not only in the hospitals and as social service workers but also in school lunchrooms, dormitories, dining halls, cafeterias, restaurants, tearooms and hotels as well as in other places of commercial work.

Murtland,[12] a vocational guidance leader, in abstracting available information regarding this profession for the Carnegie Foundation finds no record of the number of dietitians employed in the 6,103 approved hospitals of the United States. The membership of the American Dietetic Association is cited as 2,584 women in the United States, but not all of these women are employed in the hospital field. Koehne has shown that the fifty-five hospitals offering approved courses, employ 305 dietitians, almost one-third of this number being employed in six of the larger hospitals. Murtland commented on the fact that all hospitals listed in the official directory do not employ dietitians, but she feels that the trend toward required standards assures status and increased opportunity for employment.

The standards for the training of the student dietitian have shown much progress during the last decade due to the interest and cooperation of the college and the hospital with the American Dietetic Association.

The scope of activities for this profession has widened greatly and the opportunities and practices of standardization have greatly increased. There is much difference of opinion as to whether continued emphasis on standards should be greater than a concentrated study on aims and objectives of the profession which might be accepted by all of the directors of hospital dietary departments interested in the training of dietitians.

Is the standardization of an increasing number of activities and opportunities offered to students the best instrument for improvement in the practices of the profession? Should an educational philosophy of the profession be studied and a uniform underlying theme be accepted by all hospital courses, permitting the specific activities to be developed by the individual courses in accordance with the aims of individual institutions?

Progressive education places greater emphasis on the social development of the student and less on course content, and recognizes individual differences in levels of development. Therefore it seems that the time has come for the dietetic profession to study its fundamental educational plan and give all hospital training courses a uniform philosophy.

The great advance made by the profession through its inspection system must be continued but such a system being adjustable to changing conditions would seek to emphasize greater possibilities in individual institutions with lesser emphasis upon standardization.

This next step in our professional education program cannot be instantaneous but can be made only after a committee of the American Dietetic Association has agreed upon a set of objectives for all hospital training courses. Interpretation of these aims and the creation of the necessary opportunities for emphasis on fundamental experiences and social adaptation so necessary to the student dietitian should be studied and minimum standards recommended by a joint group selected from the executive committee of the American Dietetic Association and the board of trustees of the A. H. A.

The literature tends to show a confirmed belief on the part of the hospital administrator that great improvement has been made in the organization and administration of hospital dietary departments.

However, if the interest and stimulus of the hospital profession are sufficient, a large number of positions can be made available to students being trained in their institutions. If this same interest and stimulus can be directed by the hospital administrator and hospital dietitian toward the fundamental aims and objectives of student training courses, the joint problems of the two groups may be studied, thereby promoting better training for students and better dietary departments in hospitals.

No. 15—Golden Leaf Salad

By Arnold Shircliffe*

Lettuce
Orange
Green Pepper
Cream Cheese

ON A BASE of lettuce (cut flat), place seven sections of an orange. Arrange thin strips of green pepper to represent mid-rib, stem, etc. The orange sections and pepper strips can be held in place by using a cream cheese foundation.

*Author of Edgewater Beach Salad Book.

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The hospital's large service refrigerator is seen here. Fresh vegetables, fruits and milk are well represented in the supplies.

Menu Planning, Marketing and Serving Food for a Small Institution

By Florence Storey

Superintendent of Nurses and Dietitian, Municipal Tuberculosis Sanitarium, Peoria, Ill.

FOOD service in a small sanatorium is very different from that in a general hospital. It is far more simple to plan and manage because the treatment of tuberculous patients, especially when they are few in number, does not demand great variety of diets.

The first and most important step is menu planning, the second, marketing, and the third, service.

When the position of superintendent of nurses is combined with that of dietitian and housekeeper only a certain portion of the day can be devoted to supervising the food service.

The menus for this sanatorium are planned a week ahead of time. By telephoning the principal produce houses and meat dealers for anticipatory prices on fresh vegetables, fruits and meats, and consulting with the storekeeper as to staples and canned goods on hand, one can have a fairly clear picture of what may be expected for the week.

Our patients remain with us a long time and we soon become familiar with their likes and dislikes. In planning the menus, variety is the aim of the dietitian.

Meats, fresh fruits and vegetables are ordered only three times a week. However, the produce and packing houses are instructed to call, should there be more attractive foods and prices in the meantime, and since they are most cooperative often there is a slight change in the day's menu.

Canned goods and staples are contracted for every six months. An anticipatory list is made up and submitted to the leading wholesale grocers, who bid. The lowest bidder for quality is then granted a contract.

It is usually the case that each wholesale house has certain items on which its prices are lower than those of the others, although the quality of the goods is fairly equal. By selecting these items from each bid and not showing prejudice, the contracts are fairly evenly distributed among the bidders and yet the goods are purchased at the lowest possible price.

Such distribution of business is important in the management of tax maintained institutions against which the cry of political patronage is easily raised. By maintaining strict fairness to the business houses, an institution can be readily protected from such accusations and the good will of the community gained.

Our storage space being small, the wholesale grocers hold our goods at our disposal and we place our order from a week to ten days in advance. All meats and fresh produce are checked and issued by the superintendent of nurses or the storekeeper, all staples by the storekeeper, who also keeps the books on food supplies.

Our twenty-four-hour milk supply is "today's" milk and an average of 144 quarts of bottled certified milk for trays and tables, 5 gallons of bulk pasteurized milk for cooking purposes and 2½ gallons of coffee cream is used. There is no limit to the amount of milk patients may consume.

We have one general menu for all. This includes patients, staff and personnel. The medical director and superintendent prefers this system, and besides, we have a small kitchen and only three cooks. We plan service for 130 people three times a day, and have neither time nor space for preparing separate menus. When a patient's condition necessitates a special diet, this is prepared with the slightest possible deviation from the general menu.

All the cooking is done on a crude oil range, 2 1/6 by 7 1/2 feet, in the main kitchen. There are no steam tables.

MENUS FOR ONE WEEK

Monday

Breakfast	*Dinner*	*Supper*
Preserves	Baked ham	Creamed chipped beef
Hot biscuits	New potatoes, parsley	Baked potatoes
Fried eggs	Spinach	Green onions
Cereal	Watermelon	Fruit
Coffee, cocoa, milk		

Tuesday

Stewed apricots	Roast leg of spring lamb, mint sauce	Italian spaghetti
Bacon	Baked potatoes	Combination spring salad
Toast	Buttered green cabbage	Fruit
Cereal	Applesauce	
Coffee, cocoa, milk		

Wednesday

Jelly	Roast sirloin of beef butts	Buttered lima beans
Scrambled eggs	Browned potatoes	Cold cuts
Muffins	New green corn	Sliced tomatoes
Cereal	Pickled beets	Fruit
Coffee, cocoa, milk	Fresh black raspberries	

Thursday

Cantaloupe	Fried chicken with giblet gravy	Deviled eggs
Bacon	Mashed potatoes	Peanut butter sandwiches
Toast	New peas	Watermelon
Cereal	Head lettuce, choice of dressing	
Coffee, cocoa, milk	Special ice cream	

Friday

Stewed prunes	Baked trout	Potato salad
Eggs	New potatoes, parsley	Cold salmon
Crumb cake	New green beans	Green onions
Cereal	Tomato and cucumber salad	Apricot mousse
Coffee, cocoa, milk	Fresh red raspberries	

Saturday

Orange	Hamburger patties	Potato chips
Bacon	Mashed potatoes	Cold cuts
Toast	Buttered carrots	Leaf lettuce
Cereal	Head lettuce	Fruit
Coffee, cocoa, milk	Frozen fruit pudding	

Sunday

Honey-ball melon	Sirloin steak	Cottage cheese
Sweet sugar rolls	Baked potatoes	Cold cuts
Cottage roll (broiled)	Cauliflower	Pickles
Cereal	Combination vegetable salad	Radishes
Coffee, cocoa, milk	Ice cream	Fruit
		Cake

Milk, bread and butter are omitted on the dinner and supper menus because of space limitations.

All cooking is done on a crude oil range, 2 1/6 by 7½ feet, in various sized kettles of cast aluminum. We have no steam tables, nor do we use coffee urns to make coffee, but instead make old-fashioned boiled coffee in five-gallon pots. A few years ago, urns were used but were found unsatisfactory. Great care is taken in all our cooking to keep it as near the "at home" flavor as possible.

The food is taken from the stove and put directly into electrically heated food conveyors. These conveyors are then taken immediately to the floors, and the food is served at the patient's door. The cold foods, such as salads and desserts are apportioned, and put on trays in the large fruit and vegetable ice box on specially constructed shelves, each floor properly marked, and taken from the ice box directly to the patient's tray.

We serve fresh vegetables such as green beans, peas, cauliflower, lettuce, spinach and tomatoes the year round. The markets in this vicinity buy these vegetables in carload lots from California, Texas and Louisiana, at about the same price as first quality canned goods. In order to eliminate waste, the patient is asked as to his preference for the particular vegetable being served that meal. The same thing applies to fresh fruits such as grapefruit, berries, grapes.

It might be interesting at this point to tell of an enlightening experience we had in regard to butter used on tables and trays (we use only sweet cream butter). It had been the custom to slice the butter in six squares and divide in fourths. Because of butter left unused on the patients' trays, we divided the pound differently. We now slice the pound of butter in squares of ten and divide the squares in fourths, giving us forty small servings. Each person may have as many squares as he will eat, but only one square is served at the beginning of the meal. The nurses return to the rooms while the patients are eating so that the "big butter eaters" may have all they desire. A check-up on the trays revealed no waste butter and a check-up at the end of the month showed a saving of nearly 50 per cent. The butter that we save had been going into the garbage can.

Only Experienced Cooks Hired

We have three cooks, and we try to employ only those experienced in all kinds of cooking. These cooks not only prepare the food, but they also attend to the dining room for the help, which seats fourteen people. The dishes for this dining room and all utensils used in the preparation of the food are taken care of in the main kitchen by the cooks. We also have a service kitchen, where three maids are employed. Their duty is to set all trays with dishes, glassware and silver only, unset the trays and wash all patients' and staff dishes, and apportion salads and desserts.

We have two dishwashing machines, one in the service kitchen for adult patients, the other in a separate small pantry adjoining the service kitchen, for staff dishes and children's dishes, our children being treated for the childhood type of tuberculosis, which is not contagious. It is simple to keep the dishes for these groups separated since we have a different pattern of china, glass and silver service for each group. The trays are washed and reset after each meal, then put on the tray carts. We use paper tray cloths and paper service napkins. Each division has a separate tray cart.

We have also a patients' dining room for the very few patients who are able to partake of their meals in the dining room. The number is seldom over ten. We found that by using linen tablecloths in our dining room for patients, greater pride is taken in their table manners and they seem to enjoy their meals to a greater extent than when we used only the bare polished boards or trays.

The charge nurse in each department is responsible for the serving of the food from the hot food cart to the tray. The other nurses carry trays with the help of the department janitor, who at tray time scrubs his hands, dons a clean cotton denim coat to cover his "floor clothes" and becomes a "bus boy." These department jani-

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•

Analysis
Knox Gelatine

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Calcium Phosphate	1.0–1.25%
Fat	(less than) 0.1%
Moisture	13.0–14.0%
Carbohydrate	Nil

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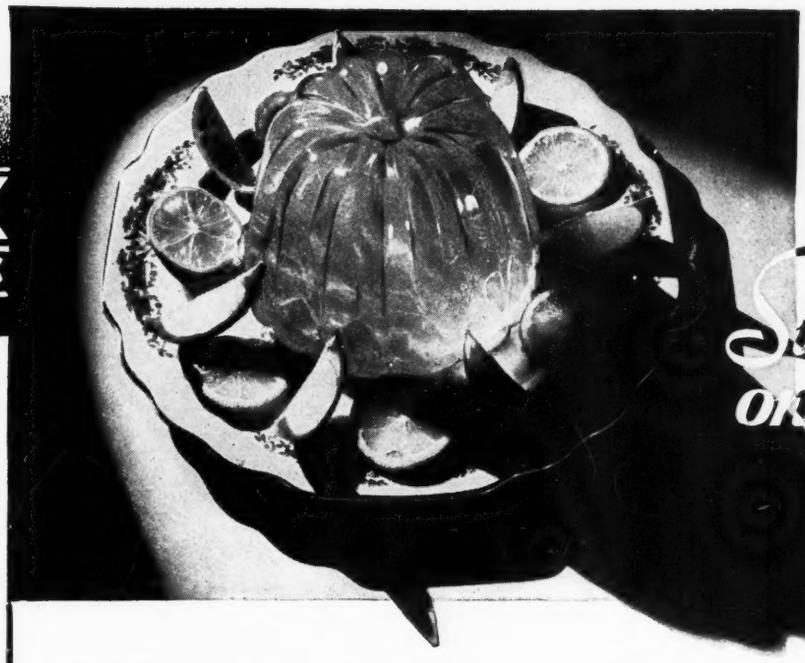

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Three maids are employed in the service kitchen, where trays are set with dishes, glassware and silver.

tors also move the food and tray carts from the service kitchen to the floors, carry all cold salads and desserts from the ice boxes to the patients' rooms and return tray carts and food conveyors to the service kitchen.

While this may sound like a rather complicated service, it is really simple.

We have in each department a floor maid who is responsible for the condition of all patients' rooms, wards, bathrooms, utility rooms, chart rooms. These maids are on their floors two full days a week out of seven. Each has one half-day a week and every second Sunday afternoon off duty. On the other days, the time from 11:30 a.m. to 2:00 p.m. and from 4:00 p.m. to 7:00 p.m. is spent in the service kitchen assisting the service maids and relieving on their afternoons off duty.

We have a small personnel in comparison to the number of patients and the amount of work to be done; 13 nurses, 3 cooks, 3 service maids, 3 floor maids and 3 janitors. The morale is splendid and we have fine cooperation from each department which is invaluable.

The charge nurse in each department is responsible for the serving of food from the hot food carts to the trays.

The per capita cost per day for raw food in 1934 was $0.4316 and for kitchen and service $0.1123, or in total $0.5439. We figure the cost per day instead of per meal, because the per diem cost includes the nourishments served between meals to patients who need food in addition to their regular meals.

In 1934 we spent $20,092.50 on raw food and $5,227.52 on kitchen and food service, a total of $25,320.02. For the first five months of the year 1935, the per capita cost per day for raw food was $0.4481, and for kitchen and dining room service $0.1154, a total of $0.5635.

Comparing the expenses for 1935 with those of 1934, we find an increase of $0.0165 per day in the raw food cost, or 3.59 per cent, which is a fair showing considering the fact that certain food prices have advanced all the way from 25 to 150 per cent in this locality.

This saving can be attributed to several things, the most important of which are: careful menu planning as to prices, and incidentally, never sacrificing quality for price; consideration of the patients' likes and dislikes; careful planning of portions, so that there is seldom any food left; the checking of all trays and garbage (the special 9-gallon garbage pail used for discarded eatable food is never more than one-third full); the weighing of all foodstuffs purchased, the checking of invoices against deliveries and the accurate disbursement of foodstuffs to the kitchen.

FOOD FOR THOUGHT

• Vitamin is old fashioned! Dr. Andrew Moldavan of Montreal thinks that the name vitamin should be discarded because it is too vague. He says it will eventually join "the musty company of phlogistic, humors, animalcules and kindred antiquated terms." The name vitamin was all right in the early days, but so much more is known about the chemical make-up of these essentials that they should be called by more specific and accurate names.

• It is interesting to note that Sophia Morse can serve more nourishments for less money at the Beth Israel Hospital, Newark, N. J., since she installed the central nourishment service. A saving of $150 a year is estimated for those floors where this system is now in effect. Its value having been demonstrated, she plans to establish the plan on the other floors.

• An interesting booklet appeared in the last few months on milk allergy. This book gives a brief resumé of what is meant by milk allergy and its manifestations and various other factors in regard to milk and its effect on those persons who are sensitive to it. Let us tell you where you can obtain it.

• Those who have enjoyed the menus will welcome the new series which starts in this issue — the Dinner Menus for the Hospital Staff. We hope that you will avail yourselves of the privilege of writing in for recipes for any dishes that are new to you, and we shall make every effort to send them to you promptly.

• Encouraging reports on the treatment of diabetes by x-raying the pituitary and adrenal glands were presented at the American Physiological Society meeting by B. O. Barnes, W. L. Culpepper and J. H. Hutton.

• Those who do not know the series of booklets "Better Buymanship" published by the Household Finance Corporation have missed something worth while. Much valuable information and many suggestions about expenditures may be found there, together with the fundamental principles of using various food products. If you haven't seen them, be sure and send for the entire series.

• A new vitamin which has been given a real name, Choline, instead of a letter, was discovered by Dr. C. H. Best, of Toronto, co-discoverer of insulin. It is essential for liver function, and may play an important rôle in controlling diabetes. A lack of this vitamin causes a condition known as "fatty liver" which prevents the liver from functioning normally in carbohydrate metabolism. The study of diabetes is moving fast!

October Dinner Menus for the Staff

By Mary McKittrick
Director of Dietetics, Mercy Hospital, Chicago

Day	Soup	Meat or Substitute	Potatoes	Vegetable	Salad or Relish	Dessert
1.	Vegetable	Roast Ribs Beef With Brown Gravy	Mashed Potatoes	Buttered Carrot Rings	Lettuce, French Dressing	Blueberry Pie
2.	Green Bean	Baked Ham With Pineapple Gravy	Parsley Potatoes	Fresh Spinach	Lettuce, Thousand Island Dressing	Rice Pudding With Cream
3.	Chicken Rice	Breaded Veal Cutlets	Escalloped Potatoes	Buttered Peas	Coleslaw	Black Raspberry Shortcake
4.	Cream of Pea and Celery	Broiled White Fish, Lemon Butter Sauce	Boiled Potatoes	Stewed Tomatoes	Lettuce, French Dressing	Butterscotch Pie
5.	Bouillon	Roast Loin Pork With Brown Gravy	Browned Potatoes	Mashed Yellow Turnips	Mixed Pickles	Prune Whip, Custard Sauce
6.	Vegetable	Chicken Fricassee With Dumplings	Mashed Potatoes	Baked Hubbard Squash	Radishes and Celery Hearts	Peppermint Candy Ice Cream
7.	Lima Bean	Frankfurters	German Potato Salad		Sliced Dill Pickles	Tapioca Cream Pudding
8.	French Onion	Stuffed Pork Chops With Fried Apple Rings	Browned Potatoes	Buttered Parsnips	Mixed Pickles	Lemon Cream Pie
9.	Chicken	New England Boiled Dinner			Lettuce, French Dressing	Red Raspberry Shortcake
10.	Vegetable	Leg of Lamb, Mint Sauce	Parsley Potatoes	Spinach, Egg Sauce	Dill Pickles	Rice Soufflé
11.	Cream of Corn	Lake Trout, Butter Sauce	Mashed Potatoes	Buttered Peas	Lettuce, Roquefort Cheese Dressing	Applie Pie and Cheese
12.	Lima Bean	Baked Short Ribs of Beef	Browned Potatoes	Harvard Beets	Lettuce, Thousand Island Dressing	Chocolate Pudding
13.	Tomato	Roast Chicken With Dressing and Giblet Gravy	Mashed Potatoes	Wax Beans	Radishes	Vanilla Ice Cream
14.	Vegetable-Rice	Leg of Veal With Brown Gravy	Parsley Potatoes	Fried Eggplant	Lettuce With Cucumbers, French Dressing	Fig Pudding
15.	Tomato Bouillon	Baked Ham, Raisin Sauce	Boiled Potatoes	Mashed Yellow Turnips	Lettuce, Russian Dressing	Rhubarb Pie
16.	Vegetable	Beef Pot Roast	Mashed Potatoes	Browned Carrots	Dill Pickles	Gelatine With Fruit
17.	Rice-Tomato	Lamb Chops With Horse Radish and Mint Gravy	Browned Potatoes	Buttered Peas	Lettuce and Shredded Vegetables	Cream Puffs
18.	Clam Chowder	White Fish, Drawn Butter Sauce	Parsley Potatoes	Buttered Wax Beans	Mixed Sweet Pickles	Blackberry Pie
19.	Vegetable	Leg of Veal With Brown Gravy	Mashed Potatoes	Escalloped Cauliflower	Ground Carrot Salad	Tapioca Pudding With Meringue
20.	Consommé	Roast Chicken With Giblet Gravy	Mashed Potatoes	Buttered Beets	Lettuce and Combination Vegetables, Mayonnaise	Maple Nut Ice Cream
21.	Lamb-Barley	Prime Ribs of Beef With Gravy	Browned Potatoes	Carrot Rings	Lettuce, Cheese Dressing	Apple Dumpling, Sterling Sauce
22.	Green Bean Chowder	Meat Loaf With Tomato Gravy	Mashed Potatoes	Onion Rings	Endive Salad, French Dressing	Pumpkin Pie
23.	Vegetable	Broiled Beef Liver and Bacon	Browned Potatoes	Whole Creamed Parsnips	Lettuce and Vegetable Gelatin Salad	Apple Tapioca Pudding
24.	Celery	Swiss Steak	Mashed Potatoes	Spinach, Lemon Sauce	Lettuce, Watercress and Radishes, Vinegar Dressing	Steamed Fig Pudding, Brown Sugar Sauce
25.	Cream of Pea	Broiled Halibut	Lyonnaise Potatoes	Grilled Tomatoes	Mixed Pickles	Blueberry Pie
26.	Oxtail	Rolled Veal Cutlets With Sage Dressing	Mashed Potatoes	Fresh Lima Beans	Lettuce, Banana Dressing	Chocolate Blancmange
27.	Rice	Stewed Chicken With Baking Powder Biscuits	Glazed Sweet Potatoes	Buttered Beets	Curled Celery and Olives	Vanilla Ice Cream, Chocolate Sauce
28.	Vegetable	Hamburger With Buns	French Fried Potatoes	Green Beans, Browned Bacon	Coleslaw	Date Roll, Foamy Sauce
29.	Lima Bean	Baked Ham, Cider Sauce	Boiled Potatoes	Creamed Peas	Coleslaw	Mince Pie
30.	Vegetable	Leg of Lamb, Mint Sauce	Boiled Potatoes	Spinach	Lettuce, Vinaigrette Dressing	Bread Pudding, Fruit Sauce
31.	Tomato-Celery	Baked Short Ribs	Browned Potatoes	Browned Onions	Shredded Lettuce	Prune Whip

Recipes for any of the foregoing dishes will be supplied on request by Anna E. Boller, The MODERN HOSPITAL, Chicago.

NEWS IN REVIEW • • • •

Utah's Medical Economics Committee Recommends Voluntary Health Insurance

A system of voluntary health insurance controlled by the state and county medical societies is recommended in the preliminary report of the committee on medical economics, public policy and relations of the Utah State Medical Association, recently made public.

The report, which is largely concerned with a survey of medical services and facilities of the state, does not attempt to set up actuarial or financial standards for such a health service but does lay down sixteen governing principles. These principles, which are in part similar to those adopted earlier by the American College of Surgeons and in modified form by the American Medical Association, may be summarized as follows:

1. Free choice of physician.
2. Control of medical service (*i.e.* treatment and prescribing) by state and county societies.
3. Confidential relation between patient and physician.
4. Divorce from unemployment insurance.
5. No third party between patient and physician in medical relation.
6. Limited to low income groups.
7. Care of indigent and marginal groups by state and profession jointly.
8. Adequate compensation of physicians.
9. Provision for preventive medicine.
10. Maintenance and improvement of professional standards.
11. Provision for cooperative research.
12. Fee basis, perhaps modified, for payment to physician.
13. Part of immediate cost to be borne by patient.
14. No commercial solicitation.
15. Master contract to be drawn by state association with subcontract by county society.
16. Initial plans to cover only a few employed groups with pay roll deduction with later consideration of extending groups and service.

Because of its sparcity of population, only 6.2 persons per square mile, Utah presents different problems from those found in other states, the committee reported. There are about 160 square miles and 1,040 persons in the state for each physician. Incomes are low, the committee estimating that at present 60 per cent of the families of the state have family incomes under $1,000 and 90 per cent under $2,000. There are wide variations in population density, per capita incomes, percentage of people on relief and distribution of physicians and hospitals in the various counties of the state.

The effect of the depression on hospitals and physicians is marked. While admissions to governmental hospitals in Salt Lake City increased from 1928 to 1933 by 61 per cent the admissions to nongovernment hospitals decreased 27 per cent. During the same period physicians' gross incomes dropped from $9,443 to $5,661, their net incomes fell from $6,131 to $3,036, their percentage of collections shrank from 75 per cent of their charges to 70 per cent and the ratio of professional expenses to gross income increased from 35 per cent to 46 per cent. The average hours of work per week for physicians was 63.7 and the net income per hour of work was $0.97, less, the committee points out, than for bricklayers, plasterers and school teachers.

Ratio of Beds to Population

Of the 36 hospitals of all types in Utah, 10 are government owned and have 55 per cent of the total beds, compared with 67.6 per cent for the country as a whole. The population per hospital bed (excluding mental and tuberculosis hospitals) is given as 298 for Utah compared with 305 for the country as a whole and 216 as an ideal ratio. For mental cases there is one bed for 407 people compared with 281 for the U. S. and 179 as an ideal. Tuberculosis provision is meager, one bed for each 10,000 people, but the death rate from pulmonary tuberculosis in 1933 was the lowest of any state.

"We are not inclined to question," states the committee, "that more and better medical care both preventive and therapeutic is needed by the people of Utah. Making the provision of this difficult we find the peculiar geographic and population distribution of Utah. We find that a large part of the population have no income and another larger part insufficient to secure (except through the charity of physicians) adequate medical care. We find physicians' incomes too low and precarious and that physicians at the same time donate a large volume of free service. We find that government units in Utah have failed to provide their proper share of hospital facilities and have made very poor provision of funds for the medical and hospital care of the indigent sick. We find nongovernment hospitals partly empty. . . .We are doubtful, in view of such failures of government units . . . that much help can be soon expected in partly providing (in health insurance) for the low income groups."

While the committee points out social injustices as underlying medical economic problems it states "we do not propose to wait for such social and economic adjustments before beginning an attempt to improve our own part in the problem."

Extensive Improvements Under Way at Baltimore City

The new general hospital building at Baltimore City Hospitals, Baltimore, has been completed and all patients on the acute medical and surgical services moved into this building.

New services for obstetric and for pediatric patients have been organized. There are available 130 beds for medicine, 130 beds for surgery, 100 beds for obstetrics and 60 beds for pediatrics. The new building also accommodates the pathological laboratory, the clinical laboratory, the pharmacy, the main dietary department, the operating rooms, the department of roentgenology, a small out-patient department and the general administrative offices.

The building formerly used for acute patients is being reconditioned, and to it will be added a new unit. The two buildings will have available 600 beds, all, with the exception of 45 beds, to be used for chronic patients. The 45 beds will be reserved for the genito-urinary service. These accommodations will be ready about the first of November, when the chronic patients, now in the infirmary building, will be moved to the new quarters. This will make possible the expansion of the infirmary and the addition of certain occupational and recreational facilities.

There is also under construction an addition to the tuberculosis building.

Pamphlets Available

Hospitals and other health and social agencies that are carrying on health education work may receive without charge limited quantities of several new and revised pamphlets issued by the Metropolitan Life Insurance Company, New York City. These are "Keeping Fit Through Exercise," which is accompanied by a chart of the various exercises recommended; "Overweight and Underweight," which includes instructions for reducing, new low and high calorie menus, food tables and exercises, and "Accident Prevention in the Home."

PWA Considers Applications From 137 Nonfederal Hospitals for $71,886,865

Recent information from the office of the Federal Emergency Administration of Public Works indicates that applications are being considered by Administrator Harold L. Ickes and his examiners from 137 additional nonfederal hospitals for $71,886,865. These buildings, including those constructed or under construction and those planned, are in every section of the United States.

A significant phase of the public works program is concerned with public health. Large sums have been spent by PWA to provide communities with adequate sewage facilities, good water systems and clean, low cost housing, while other money has gone to aid the U. S. Public Health Service and similar federal agencies in their fight against disease.

One of the important items in this health phase of the program is hospital construction. In the past two years PWA has aided in the construction of 178 nonfederal hospitals and 77 federal hospitals, costing approximately $73,000,000.

PWA loans are available for all types of hospitals — private, nonprofit community and municipal. However, grants, now 45 per cent of the total cost of the project, can be awarded only to hospitals owned by public bodies. To secure a loan, the prospective borrower must present a feasible construction project and offer security satisfactory to PWA finance officers. Like all other nonfederal applications, one from a hospital must go through the three main examining divisions of PWA. Lawyers must pass on the legal aspects of the application; engineers must agree that the hospital building or addition can be built for the sum involved; the finance men must be sure the new building, if privately operated, will be able to pay for itself and thus refund the loan. Speaking generally, PWA makes allotments for hospitals on the assumption that they are desirable socially.

Unlike housing, where PWA actually designs and builds, the hospitals are largely left to the discretion of the actual sponsor. No check is put on the type of architecture or on the plans except where changes may save money with no loss in utility. During construction, another PWA division, Inspection, makes sure that the contractor is giving full value for every dollar expended and is maintaining standards set forth in the specifications.

The new works program offers especially to municipal bodies an opportunity to add to their hospital facilities at extremely low cost to themselves. Not only are federal loans available for such projects, but the government will present the applicant with 45 per cent of the total cost of the hospital in the form of an outright grant.

Canadian Hospital Council to Hold Biennial Meeting at Ottawa in October

Arrangements have been made for the biennial meeting of the Canadian Hospital Council, to be held in Ottawa, Ont., October 8 to 10. Official delegates are expected from the twelve hospital associations in Canada and nearly all of the provincial governments. Already the federal government and many of the provinces have named their representatives.

As at the Winnipeg meeting in 1933, it is anticipated that the sessions will be entirely informal. An agenda of subjects and topics of particular interest to the hospital field is being arranged, and these will be discussed in turn. The representatives participating will be either outstanding hospital leaders in their own provinces or governmental officials closely in touch with hospital problems. The practices and experiences of every province in Canada can be drawn upon for these discussions.

Reports of the various study committees will form the basis for much of the discussion. For the past two years, some eleven committees have been actively studying hospital problems and excellent reports are anticipated. The secretary, Dr. G. Harvey Agnew, reports that several valuable studies and reviews have been completed, and the remainder are expected within the next few weeks. These will later be amplified and distributed.

The first two days of the sessions will be devoted to general subjects and will constitute the sessions proper. The third day will take the form of a special meeting to consider the details of effecting a common basis for all of the provinces of statistical returns of hospital data. Much has already been accomplished in bringing about this coordination, and this meeting of provincial representatives and the committees on accounting and on administration and statistics should complete much of the task. This session is being sponsored by the Dominion Bureau of Statistics.

Hospital Installs New Air Conditioning System

St. Vincent's Charity Hospital, Cleveland, has recently installed in one of its rooms a new system to provide year 'round air conditioning, for the study and treatment of certain clinical conditions. The equipment has provisions for admitting outside air, for maintaining a constant inside temperature at any selected value between 65° and 85° F., and for maintaining an inside relative humidity of 40 and 60 per cent regardless of the inside temperature. These conditions may be obtained at any time of the year.

The equipment with full automatic control is arranged so that the desired conditions are obtained with the minimum of attention, as the only operations required to place it in service consist of closing a switch, setting the thermostat and setting the humidistat.

After this has been done, the equipment needs no attention, until different room conditions are desired.

Flushing School Serves as Hospital

The proposed demolishment of the Children's Hospital for Mental Defectives, Randall's Island, N. Y., has resulted in patients being removed to the vacant plant of the Parental School in Flushing, Queens. Through the cooperation of the state department of mental hygiene, the number of children will be reduced from 500 to 400, the maximum capacity of the school. The building has been loaned to the department of hospitals by the board of education. No definite plans have as yet been revealed as to what disposition will be made of the children when the board of education again occupies the building.

Private Patients Increase

An increased demand for private rooms in the voluntary hospitals of New York City is reported for the first time in five years by Homer Wickenden, general director of the United Hospital Fund. His reports show that 52 per cent of the private rooms are now occupied, in comparison with 42 per cent six months ago. Improved business conditions are credited with the increase.

Employees' Health Service Begun

Health supervision of its employees is a recent step taken by the New England Health Center, comprising the Boston Floating Hospital, Boston Dispensary and Tufts College Medical School. The new plan includes routine physical examination, the keeping of records, and treatment.

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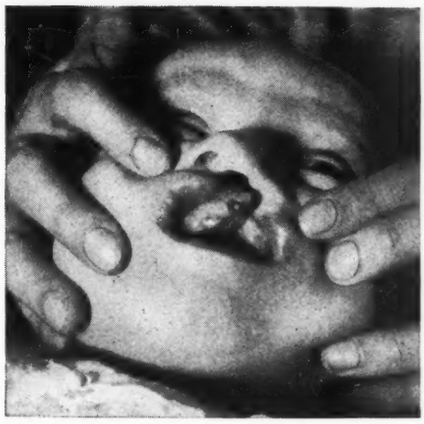

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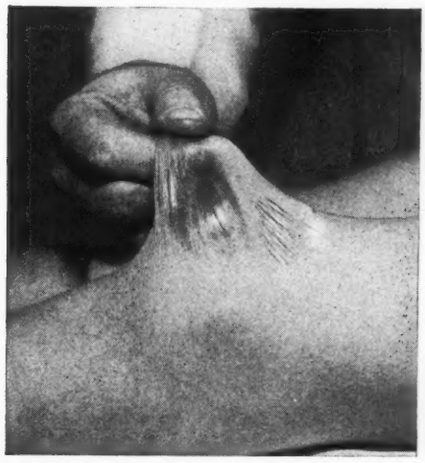

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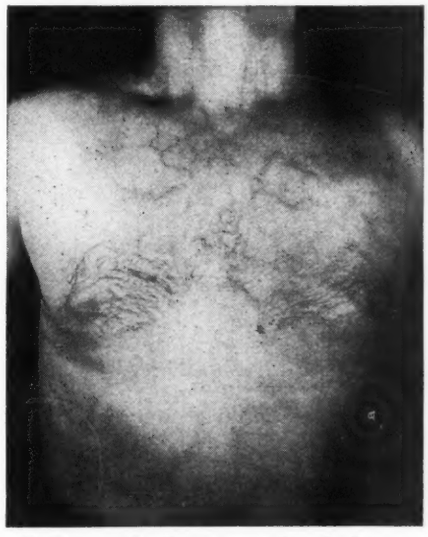

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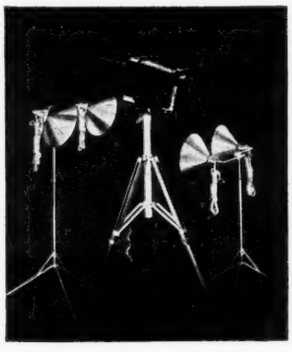

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Developments Take Place at the Neurological Institute

Dr. Frederick Tilney, professor of neurology at the College of Physicians and Surgeons of Columbia University, has been appointed to the new position of medical director of the Neurological Institute, New York City, in a reorganization effected recently. A new department is to be organized in association with the College of Physicians and Surgeons to develop research in physiology of the nervous system and it is planned to enlarge the department of child neurology recently organized under the direction of Dr. Bernard Sachs. Laboratory facilities will be expanded. Ten new committees have been appointed to deal with scientific matters, finance, hospital management, professional staff, nurses, out-patient department, education, buildings and grounds, publicity and community relations and law.

Town Meetings on Health

The five-months' nationwide health campaign sponsored by the seventeen participating agencies in the National Health Council, New York City, will culminate about October 21 in numerous old-fashioned New England town meetings for the consideration of personal and community health, according to the *American Journal of Public Health*. The campaign is being promoted in about 400 cities where official and voluntary health and social work organizations are giving their cooperation. The chairman of the committee for the campaign is Louis I. Dublin.

Artificial Radium to Be Available

A machine to manufacture artificial radium will be built this summer for the University of Rochester under the direction of Lee A. Dubridge. The five-million volt accelerator will be the second of its kind in the country, and will manufacture radium at less expense than the cost of true radium.

Two Hospitals Benefit by Will

Among recipients of legacies under the will of Mrs. Harriet Crocker Alexander, Tuxedo, N. Y., the Orthopedic Dispensary and Hospital, New York City receives $10,000 and the Tuxedo Hospital, $2,000. Also mentioned in the will is the Children's Hospital Training School of San Francisco, which is a beneficiary under the will, to the amount of $1,000.

Hospital Housekeepers Attend Summer School

Hospital women participated in the week of housekeeping classes held during the summer at the Hotel School of Cornell University. Included in the group of nineteen members who subscribed to this course were Mrs. Ida F. Catton, Memorial Hospital, Morristown, N. J., Gladys Hancock, president, Hartford chapter, National Executive Housekeepers Association, Municipal Hospital, Hartford, Conn., and Catherine Scott, Sheppard and Enoch Pratt Hospital, Towson, Md. So interested were those participating that requests are being received for a two weeks' course another year. The classes were under the direction of Prof. H. B. Meek, head of the Hotel School at Cornell, and Beulah Blackmore, head of the institutional management courses, who served as technical adviser for the housekeeping classes.

BEQUESTS AND GIFTS

ILLINOIS. — The Presbyterian Hospital received a bequest of $10,000 in the will of Mrs. Roxana Atwater Bowen, New York City, who died July 10. Mrs. Bowen was a daughter of John Wentworth, who was mayor of Chicago in 1857. The Day-Kimball Hospital, Pomfret, Conn., is another beneficiary in this estate, receiving $5,000.

INDIANA. — Eli B. Phillips, retired Newcastle banker, has agreed to give $10,000 toward the construction of a nurses' home at the Henry County Hospital provided the labor cost can be secured through the federal works relief program. The gift is estimated to amount to half the cost of the project. The money has been placed in escrow.

MICHIGAN. — Community Hospital, Big Rapids, received $6,000 through the will of the late Mrs. C. H. Milner.

OHIO. — When Dr. Benjamin S. Kline, Cleveland, received the 1935 Charles Eisenman Award of the Jewish Welfare Federation of Cleveland, in recognition of his contributions to medical science, he turned the check for $1,000 over to the Mount Sinai Hospital, where he is director of laboratories, for further research.

PALESTINE. — The sum of $7,500 was recently donated to Hadassah, the Women's Zionist Organization of America, by Baroness Edmond de Rothschild, who has since died. The money is to be used to repair the Hadassah Hospital at Safad, Palestine, the only hospital for tuberculous patients in Palestine. In the last few years the condition of the building had become so bad that the hospital would shortly have had to be condemned as unsafe as no funds for repairs were available.

PENNSYLVANIA.—Under the wills of Louis and Henry L. Weinberger the St. Luke's and Children's Hospital, the Northern Liberties Hospital and the Women's Homeopathic Hospital will each receive $5,000, and Temple University Hospital, Lankenau Hospital, Jefferson Medical College Hospital and Mount Sinai Hospital will receive $10,000 apiece. These are all Philadelphia institutions.

TENNESSEE. — A gift of $2,500,000 from the General Education Board to the medical school of Vanderbilt University has been announced. Expenditure of between $700,000 and $900,000 of this amount on a hospital addition and its equipment will, according to Chancellor James H. Kirkland, give the university a reasonably complete physical plant.

BRITISH COLUMBIA. — A gift of $2,500 for the purchase of radium has been received by the Provincial Royal Jubilee Hospital from Mrs. Sayward-Wilson.

NEW BUILDING PROJECTS

FORT LYON, COLO.—An appropriation of $691,700 has been allotted to the Veterans Administration Facility by the Veterans Administration, for additions.

CHICAGO.—A new $8,000 library will be built on the roof of Ravenswood Hospital. It is expected that construction will begin about September 1. The present library on the third floor, with shelves for 4,000 books and over 100 monthly periodicals, has been outgrown and space is needed for new books and new study rooms.

MAYFIELD, KY.—Fuller Gilliam Hospital announces plans for the construction of a larger and more modern hospital building, costing about $75,000. Work will be begun about September 1 and it is expected to be finished by next January.

MURRAY, KY. — A campaign is under way to raise funds for a new building for the William Mason Memorial Hospital to replace the one recently destroyed by fire. Tentative plans are for a two-story structure with an above ground basement, and a capacity of eighty-two beds.

TRAVERSE CITY, MICH.—Plans are under way for the construction of a $75,000 children's hospital, bids for the contract having been closed recently. The undertaking is being financed by the Children's Fund of Michigan. A special act of legislature leasing the property made the proposed building of the hospital possible.

NEW YORK CITY.—Under the terms of the will of Dr. Walter P. Silleck, Harlem Hospital is the recipient of a trust fund of $500 with which to provide Christmas presents annually for children in that institution.

CINCINNATI. — Contracts were recently awarded for the erection of a $36,169 school building for children in the preventorium at the Hamilton County Tuberculosis Sanatorium.

CLEVELAND. — St. Vincent's Charity Hospital has recently completed a new isolation room in the pediatric unit, furnished and equipped with all modern devices for rendering efficient service.

TOLEDO, OHIO. — Work has been resumed upon the William W. Roche Tuberculosis Sanitarium. It was halted shortly after the excavations were completed when the FERA workers struck in protest against the budgetary system of pay.

WILMINGTON, OHIO. — According to plans announced by the commissioners of three counties, Clinton, Greene and Warren, the old Clinton County Infirmary, which was abandoned in 1928 for a new building, will be rebuilt and converted into a tuberculosis sanitarium for patients from these counties.

WOOSTER, OHIO. — The Lodi Hospital has let the contract for the construction of an addition to the main building to house new operating and x-ray rooms. The addition will be a one-story fireproof structure and between the two rooms a receiving entrance and hall will be built.

LONDON, ONT. — Announcement is made that a new surgical pavilion will be erected at Queen Alexandra Sanatorium to cost from $85,000 to $100,000. With the greater use of surgical treatment in tuberculosis the present surgical facilities have been found inadequate. The building will have forty-two beds and various laboratories.

LONDON, ONT. — Over $23,000 is to be spent in connection with Westminster Military Hospital. A $5,300 contract for exterior painting of the buildings has been let and this work is already under way, while plans have been prepared for an $18,000 reservoir with a capacity of 300,000 gallons for the hospital.

ONTARIO. — Four new clinics for prevention and treatment of tuberculosis are to be established in Ontario, according to an announcement by Premier Hepburn. Dr. G. C. Brink, who now heads the Toronto clinic, recommends that the new clinics be in Ottawa, Belleville, North Bay and Fort William.

HULL, QUE. — A sanatorium for the care of tuberculous patients is to be built and will be under provincial jurisdiction. It will serve the western section of the province of Quebec. The building will accommodate seventy-five beds and will cost approximately $300,000. It will be under the supervision of the Grey Nuns of the Cross.

OAKVILLE, TENN. — Plans for improvements at Oakville Memorial Sanatorium with PWA and WPA funds are under way. A fifty to sixty-bed wing, two stories high, of concrete construction, is estimated to cost about $85,000. A similar wing was added last year. A $9,000, one-story manual training building is also being designed, to be used for training patients for gainful occupation that will not impair their health after they leave the hospital.

EL PASO, TEX.—Additions and alterations are planned for the City County Hospital. The work is to be paid for out of a new PWA loan and grant totaling $27,000.

BELLINGHAM, WASH.—The building of a federal psychiatric hospital is now assured with the approval of the expenditure of $2,322,000 for the purpose. It is estimated that it will accommodate 750 patients, largely Indians from Alaska and the Pacific Northwest.

BREMERTON, WASH.—A $20,000 addition to the Olympic Hospital is under consideration according to a recent announcement.

MARSHFIELD, WIS.—A four-story fireproof structure is to be added to St. Joseph's Hospital. The architects are E. Brielmaier and Sons, Milwaukee.

RHINELANDER, WIS.—St. Mary's Hospital is to be remodeled and an addition built. It is owned by the Sisters of the Sorrowful Mother.

Cancer Institute to Move to New Quarters

Brooklyn Cancer Institute, Brooklyn, N. Y., will at the end of the year be transferred from its present quarters at Cumberland Hospital to a new building on the grounds of Kings County Hospital. Dr. S. S. Goldwater, commissioner, department of hospitals, New York City, has announced that the autonomy of the institute will be preserved. His announcement followed interdepartmental discussion concerning the future status of the institute. According to an alternative plan the institute would have become a clinical subdivision of the Kings County Hospital.

The specialist staff of the institute will include radiation therapists, pathologists, roentgenologists, internists, surgeons, gynecologists, laryngologists, dermatologists, dentists, consulting neurologist and consulting ophthalmologist. The proposed budget provides for a full-time director. The nonmedical staff of the institute will include social service workers, a physicist, photographer, radiation technicians and secretarial staff.

There will be an out-patient department for the diagnosis and treatment of ambulatory patients. The in-bed department for the study and treatment of nonambulatory patients will comprise eighty beds. An active research program is contemplated and systematic training in diagnosis and treatment will be offered to physicians.

It is proposed to rename the Brooklyn Cancer Institute and various titles are under consideration. A less forbidding name is sought and one that will reflect the functions of education, prevention and control, as well as the function of routine treatment. Medical experts and general workers have been invited to submit suggestions.

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Protestant Meeting Is Curtain-Raiser Among Hospital Conclaves in St. Louis

In line with the decision reached last year, the American Protestant Hospital Association has formulated a program directed primarily toward the distinctive work of church hospitals and the relations between churches and hospitals. The sessions, to be held at the New Jefferson Hotel, St. Louis, open on Saturday, Sept. 28 and close on the following Monday morning.

The Saturday morning session will consist of addresses as follows: Dr. C. S. Woods, Cleveland, on "Sources of Money for Voluntary Hospitals"; Carolyn E. Davis, Portland, Ore., on "What of the Future of Our Church Hospitals?"; J. G. Norby, Minneapolis, on "The Relations of Church and Hospital"; Frank C. Gabriel, accountant, Presbyterian Hospital, Chicago, on "Advantages of Uniform Accounting to Church Hospitals," and C. Rufus Rorem, Chicago, on "Group Hospitalization as It Relates to Church Hospitals."

At luncheon President C. C. Jarrell will report on the work of the joint hospital committee, and Albert G. Hahn will direct a discussion of the outstanding spiritual accomplishments in church hospitals during the past year.

Saturday afternoon will be devoted to nursing in church hospitals with papers by Fannie Forth, Indianapolis, and Walter G. Christie, Denver, followed by a round table on problems of the church hospital led by Dr. Malcolm T. MacEachern, American College of Surgeons, Chicago.

The president's session on Saturday night will be devoted to the annual address of the president, and a discussion of the value of church hospitals to religion by Robert Jolly, Houston, Tex. Robert E. Neff, Iowa City, will speak on "What the Protestant Hospitals Can Do to Promote the Work of the College of Hospital Administrators."

Religious programs are planned for Sunday in the various St. Louis churches and a business breakfast meeting is scheduled for Monday morning. At this meeting Paul Fesler, Chicago, will speak on "What of the Future of the American Protestant Hospital Association?"

Occupational Therapists Plan Vigorous Program

When the American Occupational Therapy Association opens its convention in St. Louis on Tuesday, October 1, it will be the nineteenth annual meeting of the organization. President Joseph C. Doane, medical director, Jewish Hospital, Philadelphia and editor, The MODERN HOSPITAL, will give his presidential address at the opening session. The O. T. program at Queen's Hospital, Honolulu, will be described by Laura L. Dowsett.

Tuesday evening at the annual banquet Father Alphonse M. Schwitalla, Robert Jolly, and Sidney I. Schwab of St. Louis will speak.

The Wednesday morning session will be devoted to occupational therapy in neuropsychiatry. A luncheon at the Elias Michael School for Crippled Children will be followed by a discussion of the interrelationship of services for the crippled child. The afternoon session, to be held at the Washington University Medical Center, will take up rehabilitation in orthopedic surgery and in heart disease and the general rehabilitation program of Missouri. This will be followed by a visit to the curative and preindustrial shop.

Tuberculosis and occupational therapy will be discussed by three speakers on Thursday morning and the expense of an O. T. program will be considered at an informal luncheon at St. Luke's Hospital. The concluding session that afternoon will consist of a visit to St. Louis School of Fine Arts in Washington University, followed by a picnic supper.

National Hospital Association Meets in New Orleans

The annual meeting of the National Hospital Association was held in New Orleans, August 11 to 17, in conjunction with the National Medical Association and the National Association of Colored Graduate Nurses. The meetings were held on the campus of the new Dillard University which has its formal opening this fall. All sessions were well attended.

Dr. E. B. Perry, Kansas City, Mo., president of the National Hospital Association, opened the meeting. The presidential address entitled "Looking Forward" was received with enthusiasm and served as a standard for subsequent meetings.

High lights of the hospital meeting included two papers by C. Rufus Rorem of the Julius Rosenwald Fund, Chicago, on "Hospital Accounting" and "Medical Economics." Doctor Rorem emphasized the importance of group hospitalization movements as a means of combating the high cost of medical care in the face of decreased family budgets.

The paper of A. W. Dent, superintendent, Flint-Goodridge Hospital, New Orleans, on "Modern Hospital Administration" was timely and of interest to all hospital administrators. He summarized most of the important problems facing the hospitals of today and discussed at some length those of the greatest moment.

Dr. Peter Marshal Murray, New York City, presented an interesting discussion on "The Possibilities of the Local Medical Society in the Program of Medical Education." Dr. Murray took an active part in all of the meetings.

Pearl McIver, R.N., played an important rôle in both the hospital and nursing sections. In her formal paper on "Public Health Nursing," she explained a few of the projects in her field which are now going forward under the sponsorship of the federal government.

Officers elected for the coming year are: president, Dr. E. B. Perry, City Hospital No. 2, Kansas City, Mo.; vice president, Dr. R. M. Hedrick, St. John Hospital, Gary, Ind.; secretary, Dr. S. W. Smith, Provident Hospital, Chicago; treasurer, Petra Pinn, R.N., Norfolk Community Hospital, Norfolk, Va.

Nurse Anesthetists to Discuss Practical Topics

The National Association of Nurse Anesthetists, meeting simultaneously with the A. H. A. in St. Louis on October 1 to 3, has arranged a practical program. Tuesday afternoon will bring the president's address by Mrs. Gertrude L. Fife, University Hospitals, Cleveland, followed by three specific discussions of anesthesia problems. The annual banquet is scheduled for Tuesday evening. Dr. Louis H. Burlingham, and Dr. Ernest Sachs, both of St. Louis, will be the speakers.

On Wednesday morning clinic sessions will be held at Barnes Hospital and a business session in the afternoon. Thursday morning Myra Belle Quarles, Oakland, Calif., will discuss "Anesthesia in Childhood" and Louise Schwarting, Madison, Wis., will speak on "Facts Found in Other Fields of Practical Value in Anesthesia." Those attending the concluding afternoon session will hear Dr. Willard Bartlett, St. Louis; Mary Muller, Durham, N. C., and Miriam Shupp, Rochester, N. Y.

To Hold Breakfast Meeting

The Tri-State Hospital Association, comprising Indiana, Illinois and Wisconsin, will have a breakfast meeting in St. Louis on Wednesday, October 2, at the Jefferson Hotel, according to an announcement by Maurice Dubin, Mount Sinai Hospital, Chicago, secretary of the association.

A. C. H. A. to Induct 76 New Members at St. Louis

Governor Paul V. McNutt of Indiana will be the guest speaker at the second banquet and convocation program of the American College of Hospital Administrators meeting in the Hotel Statler, St. Louis, on Sunday, September 29. At this meeting seventy-six administrators will be formally inducted to membership in the college, having been chosen from a

total of 156 applicants considered for the year. Governor Guy Park of Missouri and Mayor Bernard Dickman of St. Louis will extend greetings to the members and guests of the college. Robert E. Neff, president, will preside and Dr. Fred G. Carter, president-elect, will deliver the presidential address.

The Monday morning program will be built around the report of a committee on the work of the hospital administrator. Doctor Carter, who is chairman of this committee, will present the main findings. Dr. Basil C. MacLean, Strong Memorial Hospital, Rochester, N. Y., will discuss "The Administrator and the Governing Board." "The Administrator and the Hospital Field" will be the subject of Dr. G. Harvey Agnew, secretary, Canadian Hospital Council, Toronto. Dr. A. C. Bachmeyer, University of Chicago Clinics, will speak on "The Administrator and the Community" and Robert Jolly, president, A. H. A., on "The Administrator and His Hospital."

The college invites all hospital administrators to these meetings.

At the exhibit of the college, copies of the reports of the study committee on the hospital administrator and the survey of the hospital administrative field may be obtained.

Record Librarians to Assemble in San Francisco in October

A program featuring both practical demonstrations and "big names" will be presented at the seventh annual conference of the Association of Record Librarians of North America, meeting simultaneously with the American College of Surgeons in San Francisco the end of October. Two sessions will be held jointly with the college and the program for these is presented with the college program elsewhere in this issue.

The record librarians main program will start on Tuesday morning, October 29, as Monday is devoted to registration and a tea. Tuesday morning the librarians will be greeted by Estelle Metcalf, Oakland, representing the Association of Record Librarians of Northern California, and Mabel Hayles, representing the Southern California group. Dr. Malcolm T. MacEachern and Dr. R. C. Buerki will address the association. Edna K. Huffman, record librarian, St. Joseph's Hospital, Chicago, will deliver the presidential address which will be followed by a business meeting.

After luncheon a tour of San Francisco and vicinity has been planned by the arrangements committee.

Wednesday morning and afternoon are devoted to the joint meetings with the American College of Surgeons and Wednesday evening to a tour and dinner in Chinatown.

The Thursday morning session will consist of a symposium on medico-legal problems and a round table conducted by Robert Jolly. Participating in the symposium will be Charles Sullivan, attorney, Dr. Rodney A. Yoell, Gilmore War, U. S. Fidelity and Guaranty Co., and Mrs. Grace Finchley, record librarian, St. Francis Hospital, all of San Francisco, Calif.

Various topics are scheduled for Thursday afternoon. Estelle Freidinger, assistant director, California State Nurses Association, will tell how nurses may be aided in appreciation of clinical records. Dr. B. W. Black, medical director, Alameda County Hospitals, Oakland, will discuss the function of the record committee, and Miss M. A. Buck, record librarian, University of California Hospital, San Francisco, will speak on the value of cross indexing. The registry of the association will be presented by Dorothy Gilman, chairman of the board of registration and record librarian, Kings County Hospital, Seattle.

At the annual banquet that evening Robert Jolly will preside.

Housekeeper Delivers Radio Talk

"The Executive Housekeeper" was the subject of a talk delivered over the National Broadcasting Company's station KPO by Mrs. Alice M. Eldridge, president of the Oakland, Calif., chapter of the National Executive Housekeepers Association. Mrs. Eldridge who is executive housekeeper of the Fairmont Hospital, San Leandro, Calif., described some of the problems which the institutional housekeeper faces in her daily work.

Coming Meetings

Institute for Hospital Administrators.
Next meeting, Chicago, Sept. 11-25.

American Protestant Hospital Association.
President, Dr. Charles C. Jarrell, 405 Wesley Memorial Building, Atlanta, Ga.
Executive secretary, E. E. Hanson, Lutheran Deaconess Home and Hospital, Chicago.
Next meeting, St. Louis, Sept. 27-30.

American College of Hospital Administrators.
President, Robert E. Neff, University of Iowa Hospitals, Iowa City, Iowa.
Director-general, J. Dewey Lutes, Ravenswood Hospital, Chicago.
Next meeting, St. Louis, Sept. 29-30.

American Hospital Association.
President, Robert Jolly, Memorial Hospital, Houston, Tex.
Executive secretary, Dr. Bert W. Caldwell, 18 East Division Street, Chicago.
Next meeting, St. Louis, Sept. 30-Oct. 4.

American Association of Medical Social Workers.
President, Lena R. Waters, University of Pennsylvania Hospital, Philadelphia.
Executive secretary, Mary M. Maxwell, 18 East Division Street, Chicago.
Next meeting, St. Louis, Sept. 30-Oct. 4.

Children's Hospital Association of America.
President, Robert B. Witham, Children's Hospital, Denver.
Secretary-treasurer, Agnes O'Roke, Kosair Crippled Children Hospital, Louisville, Ky.
Next meeting, St. Louis, Sept. 30-Oct. 4.

American Occupational Therapy Association.
Secretary-treasurer, Mrs. Eleanor C. Slagle, 175 Fifth Avenue, New York City.
Next meeting, St. Louis, Sept. 30-Oct. 4.

National Association of Nurse Anesthetists.
President, Gertrude L. Fife, 2065 Adelbert Road, Cleveland.
Next meeting, St. Louis, Oct. 1-3.

American Public Health Association.
President, Dr. Eugene L. Bishop, Nashville, Tenn.
Executive secretary, Dr. Reginald M. Atwater, 50 West Fiftieth Street, New York City.
Next meeting, Milwaukee, Oct. 7-10.

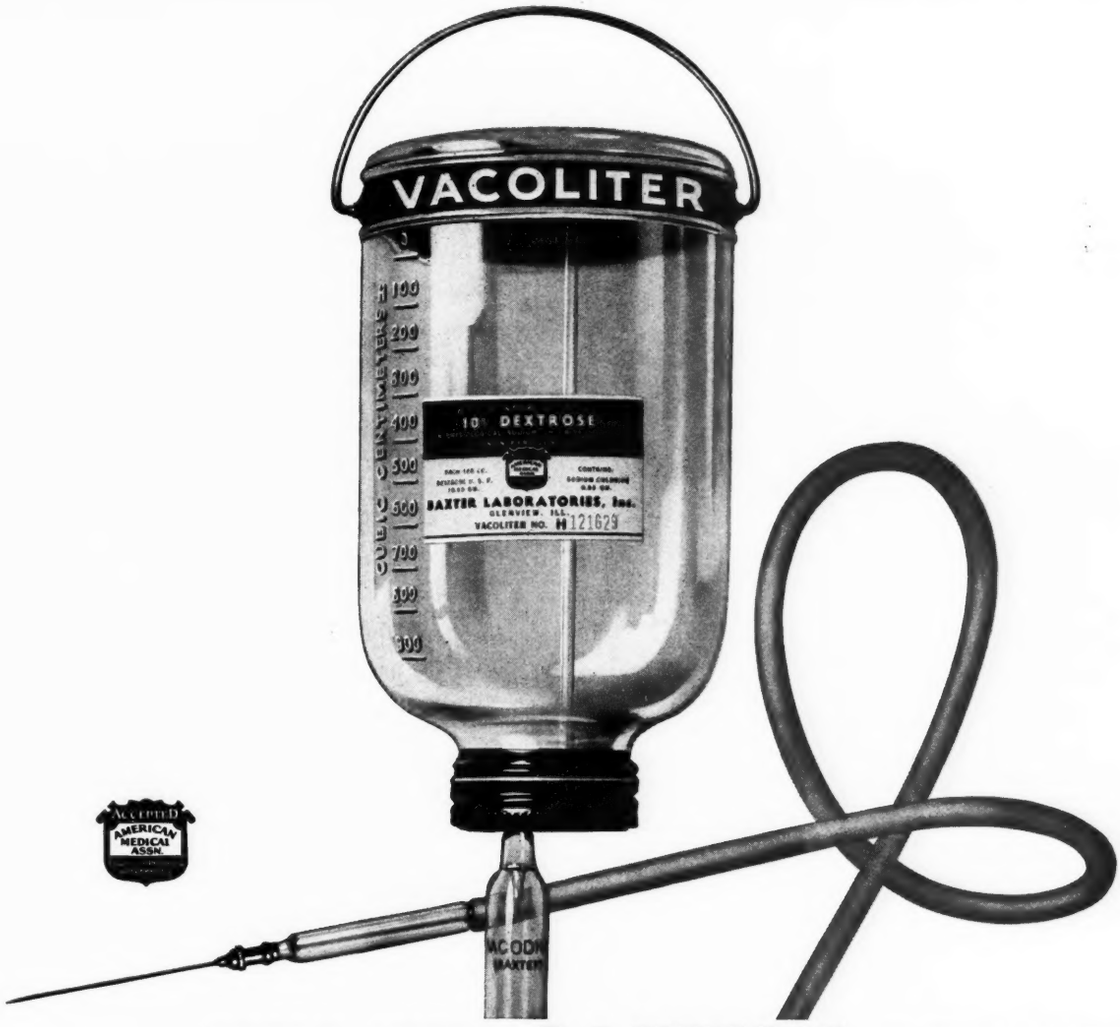
Ontario Hospital Association.
President, Brig. Gen. C. M. Nelles, C. M. G., Niagara-on-the-Lake
Secretary-treasurer, Dr. Fred W. Routley, Maple.
Next meeting, Toronto, Oct. 15-17.

American Dietetic Association.
President, Laura Comstock, Rochester, N. Y.
Business manager, Dorothy I. Lenfest, 185 North Wabash Avenue, Chicago.
Next meeting, Cleveland, Oct. 28-31.

American College of Surgeons.
President, Dr. Robert B. Greenough, Boston.
Director-general, Dr. Franklin H. Martin, 40 East Erie Street, Chicago.
Next meeting, San Francisco, Oct. 28-Nov. 1.

Association of Record Librarians of North America.
President, Edna K. Huffman, St. Joseph's Hospital, Chicago.
Corresponding secretary, Helen Hays, St. Alexis Hospital, Cleveland.
Next meeting, San Francisco, Oct. 28.

Alberta Hospital Association.
President, S. H. Adams, Calgary.
Secretary-treasurer, James Rodgers, Municipal Hospital, Drumheller.
Next meeting, November.



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Ontario Hospital Group Announces Program Plans for October Meeting in Toronto

The twelfth annual convention of the Ontario Hospital Association will take place in Toronto, October 15 to 17, when a varied program will be presented and an exhibit of hospital equipment and supplies will be on view.

At the opening session Dr. D. M. Robertson, president of the association, will preside and an address of welcome will be given by Hon. Doctor Faulkner, minister of health of Ontario. The luncheon speaker will be C. Rufus Rorem, Julius Rosenwald Fund, Chicago, who will discuss group hospitalization.

At the afternoon session Dr. Grant Fleming, McGill University, will speak on state medicine. He will be followed by Dr. Harvey Agnew, department of hospital service of Ontario Medical Association, whose subject will be group hospitalization schemes. J. H. Coones, president, Ontario Society of Radiological Technicians, will give an address on "The Work of the Radiological Technician."

On the second day at the morning session the chairman will be Mrs. O. W. Rhynas, president, Women's Hospital Aids Association. On the program will be Madge McCort, Peninsular Sanatorium, St. Catharines, who will give a survey of volunteer service in her institution; Marion Lindeburg, R.N., Training School, McGill University, speaking on "Nursing Yesterday and Today"; Dr. Gordon P. Jackson, medical officer of health, Toronto, whose subject will be "The Arrangement of Clinics for Diagnosis," and Dr. W. J. Gardiner, University of Toronto, who will discuss physiotherapy in relation to hospitals. Following the afternoon session there will be a round table discussion led by Dr. Clare Brink.

The banquet will be held on the evening of the second day, when the president will give his address.

The third day will be devoted largely to reports of sections, the business meeting, the report of the nominating committee and the election of officers. An address on "The Organization and Functioning of the Nursing Service in a Hospital," will be given by Dr. M. T. MacEachern, American College of Surgeons, Chicago.

Meeting in conjunction with the Ontario Hospital Association will be the Women's Hospital Aids Association.

Illinois Legislature Acts on Group Hospitalization

A bill to provide for and regulate nonprofit group hospitalization corporations has been passed by the Illinois legislature. The bill specifically exempts such corporations from the provisions of the insurance code of the state and from all state and local taxes except on real property. It limits the hospitals which may provide benefits to those maintained by the state or its political subdivisions, or maintained by a corporation organized for hospital purposes under the laws of the state or "such other hospitals as shall be designated by the state department of public welfare."

The directors of the corporation must be hospital trustees or superintendents or physicians or dentists. The articles of incorporation must be approved by both the insurance director and the state department of public welfare. The former official must approve the rates charged and the latter must approve the rates of payment to hospitals. Annual statements must be filed with the insurance director and he shall have power to examine the books of the corporation, and to approve the costs of solicitation of subscribers. The investment of the corporation's funds is also controlled.

Provision is made for the submission of any dispute between the corporation and a contracting hospital to the department of welfare for decision.

A group hospitalization plan for Chicago has been discussed for some years and interest has recently been shown by the Chicago Community Fund, which, it is understood, is willing to finance the initiation of the plan whenever the hospitals are ready to undertake it. The Chicago Hospital Association has recently appointed a committee headed by J. Dewey Lutes, superintendent, Ravenswood Hospital, to study the subject.

To Discuss Group Hospitalization

A round table discussion of the problems of administration and promotion of group hospitalization has been called by C. Rufus Rorem, A. H. A. consultant on group hospitalization, to meet at 4:00 p.m. Monday, September 30 at the Jefferson Hotel, St. Louis, at the time of the A. H. A. convention. While the meeting is not to be a part of the official program of the convention and invitations have been sent only to executives of group hospitalization plans, Doctor Rorem announces that any interested person may attend. Early interest in the round table is widespread.

Hospital Outlines Needs in Year Book

The fiftieth anniversary year book of the Memorial Hospital, New York City, which is for the treatment of cancer and allied diseases, declares that the institution is "strained to its fullest capacity to meet increasing demands for special cancer service."

Dr. James Ewing, chairman, reporting for the medical board, said that more than 4,500 cases a month are seen in the hospital's nine clinics. Its 109 beds all are occupied. About one-third of the hospital's services are free. The causes of cancer and similar diseases are studied constantly by thirty-five workers in four laboratories.

The hospital, according to the report, needs an unrestricted addition to its general endowment funds, a pavilion for advanced and convalescent cases, endowments for the social service and radiation therapy departments, endowment of a statistics department and enlargement of the ward service.

Poland's Hospitalization Goal

The ministry of social welfare in Poland estimates that the proportion of hospital beds to each thousand urban inhabitants should be five, while the rate for the rural population should be at least two, according to the *Journal of the American Medical Association's* correspondent.

At present only the city of Warsaw and the Slaski province are adequately supplied with hospital accommodations, with the cities of Cracow and Posen having 90 per cent of their quota. Remaining cities and provinces have a bed supply of between 10 and 50 per cent of that desired.

N. Y. City Gets New Ambulances

Twelve new ambulances have been delivered to New York City for use by certain of the city hospitals. They are inclosed units, equipped with roller stretcher beds, four wheel brakes, shatterproof glass and semi-balloon tires.

Establishes Blood Donors' Bureau

The Providence Medical Association, Providence, R. I., has established a bureau for professional donors of blood. All donors must have negative Wassermann reactions and normal hemoglobin and be in good physical condition. Calls are handled through the Physicians and Surgeons Exchange. Dr. Francis H. Chafee is chairman of the committee that established the service.

American College of Surgeons Plans Varied Program for San Francisco Meeting

Hospital people are going West. St. Louis, where the A. H. A. meets the end of September, will be West for most hospital administrators. But the American College of Surgeons will do a thorough job of it and meet in San Francisco. The eighteenth annual hospital standardization conference will convene at the Fairmont Hotel concurrently with the clinical congress of the college in San Francisco on October 28 and last through November 1.

The opening session on Monday morning, October 28, will be welcomed by Dr. Jacob C. Geiger, San Francisco, director of public health, and Dr. Leon M. Wilbor, superintendent, San Francisco Hospital and president-elect, Western Hospital Association. Dr. George Grile of Cleveland will report on the hospital standardization work of the college and will announce the approved list of hospitals for 1935.

Other speakers at the opening session will be: Sister John Gabriel, hospital consultant and educational director, Sisters of Charity of Providence, Seattle, on "The Hospital and the Changing Social Order"; Dr. Irvin Abell, professor of clinical surgery, University of Louisville, on "Opportunities for the Training of Surgeons in the Approved Hospital"; Dr. R. C. Buerki, president-elect, A. H. A., on "Organization and Administration of an Oxygen Therapy Service in a General Hospital" (with motion pictures); Dr. Philip Hillkowitz, secretary, American Society of Clinical Pathologists, Denver, on "An Accredited Pathologist for Every Approved Hospital," and Robert Jolly, president, A. H. A., on "The Future of the Voluntary Hospital."

Standardization to Be Considered

The afternoon session on Monday will be devoted to a discussion of the principles of hospital standardization from different points of view. The hospital trustee will be represented by W. C. Crandall, trustee, Scripps Memorial Hospital, La Jolla, Calif.; the hospital administrator by Paul Fesler, Wesley Memorial Hospital, Chicago; the medical staff by Dr. Jacob F. Highsmith, Highsmith Hospital, Fayetteville, N. C.; the pathologist by Dr. Alvin G. Ford, Pasadena Hospital, Pasadena, Calif.; the radiologist by Dr. Edward S. Blaine, Los Angeles; the nurse by Sister Mary Stephanie, president, Western Catholic Hospital Association; the dietitian by Lucile Waite, Fairmont Hospital, San Leandro, Calif.; the medical social worker by Marguerite L. Spiers, Alameda County Hospital, Oakland; the medical educator by Dr. Alexander R. Munroe, professor of surgery, University of Alberta, Edmonton, and the economist by Dr. Daniel Crosby, Oakland, Calif.

Arthur M. Calvin, St. Paul, will preside on Tuesday morning. The first speaker scheduled is G. W. Olson, Los Angeles County Hospital, on "Innovations in Hospital Equipment and Supplies." A. C. Jensen, Fairmont Hospital, San Leandro, Calif., will discuss the institutional care of chronic and convalescent patients. A panel discussion conducted by Joseph G. Norby, Fairview Hospital, Minneapolis, will feature Frank J. Walter,

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Denver, on public relations, G. Waite Curtis, San Francisco, on adequate service, R. E. Heerman, Los Angeles, on hospital costs within reach of the people, J. V. Buck, Spokane, on adequate service to indigents, and Carolyn E. Davis, Portland, on education of nurses, doctors and others engaged in the care of the sick.

The afternoon session on Tuesday will consist of a series of demonstrations and round table discussions conducted at St. Mary's Hospital, San Francisco, by Sister Mary Thomasine, superintendent, and the department heads of the hospital. These will cover business administration, organization and management of food service, of pharmacy service and of the adjunct departments. That evening, in St. Mary's Hospital, Robert Jolly will hold a round table conference on everyday hospital problems.

The Wednesday morning session will be a joint meeting with the Record Librarians of North America with Doctor Buerki presiding. Discussion will be opened by Dr. Malcolm T. MacEachern, associate director, American College of Surgeons, who will speak on "Securing, Supervising and Using Medical Records." This will be discussed by Dr. Theodore E. Swartz, Highland Hospital, Oakland, Calif., Dr. S. Marx White, University of Minnesota Medical School, Minneapolis, Dr. E. W. A. Ochsner, Tulane University, New Orleans, Dr. Donald G. Tollefson, University of Southern California, Los Angeles, Dr. William W. Pearson, Des Moines, Ia., and Minnie G. Hill, California Hospital, Los Angeles. "Group Studies Essential to Scientific Efficiency" will be the final topic of the morning to be presented by Sister M. Servatia, record librarian, St. Mary's Hospital, Kansas City, Mo.

Two demonstrations are scheduled for Wednesday afternoon. One of them at the San Francisco Hospital under the direction of Dr. Leon M. Wilbor, will deal with the care of the obstetric patient in the general hospital. The other will be conducted by F. S. Durie, University of California Hospital, and his department heads. It will deal with the organization and management of the medical records department.

The community health meeting which has become so prominent a part of the college's sessions will be held Wednesday evening in the city auditorium.

Thursday has been designated as "Oakland Hospital Day." Demonstrations of economies in hospital management will be presented by Providence Hospital, of the organization and management of the housekeeping department by Fairmont Hospital, and of the medical social service department by Alameda County and Berkeley General Hospitals. After luncheon at Peralta Hospital, admission and discharge procedures will be demonstrated by Samuel Merritt and Peralta Hospitals, with additional demonstrations of a central supply room by the former and a hospital formulary by the latter institution. These afternoon sessions will be held at Samuel Merritt Hospital.

The last day of the conference, Friday, will be devoted to an inspection of the emergency system in the Alameda County Hospital and a tour of the county institutions to study the "Alameda Plan."

Expands Courses in Nursing

To meet the pressing need for more adequate professional education for nurses the College of Saint Teresa, Winona, Minn., has provided an expanded full-year program to become effective in September. Sister M. Domitilla, director of nursing education, St. Mary's Hospital, Rochester, Minn., has been appointed head of the department in nursing education. It is the aim of the college to prepare nurses for the work of administration, supervision, and teaching in schools of nursing. Although the principles of nursing school organization, the principles of nursing education, the revision of the national curriculum for schools of nursing, and issues in nursing education are major factors in the development of the course of study, the cultural and social phases of the nurse's education are given due emphasis at the college.

NAMES IN THE NEWS...

DR. JAMES W. MANARY has been named head of Boston City Hospital, Boston, to succeed the late DR. JOHN J. DOWLING. Doctor Manary has been acting director of the hospital for several months and a member of the staff since March, 1908.

KATHERINE TUCKER, general director of the National Organization of Public Health Nursing since 1929, has been appointed director of the new department of nursing education established by the University of Pennsylvania at the request of the Pennsylvania State Nurses' Association. RUTH BOWER, principal of the school of nursing, Western Pennsylvania Hospital, Pittsburgh, will serve as professor of nursing education and ANNIE W. GOODRICH, who was the organizer and is now dean emeritus of Yale University School of Nursing, has been named lecturer on nursing education.

MRS. BESSIE HASKIN has been appointed to fill the vacant superintendency at the Francis Warren Pershing Memorial Hospital, Cheyenne, Wyo. She will fill the place of ANNA G. WILLIAMS who recently accepted a position with the Queens Hospital, Honolulu. Mrs. Haskin was for seven years superintendent of Denver General Hospital, Denver.

DR. NORMAN A. MCCORMICK, Windsor, Ont., has been appointed director of the new Windsor Cancer Clinic at the Metropolitan General Hospital. He will be responsible to the government for the custody of the radium, for the collection of scientific records, treatment and follow-ups and will have control of the deep x-ray therapy machine and treatments by the machine. Doctor McCormick was actively associated with SIR FREDERICK BANTING and DOCTOR BEST in the development of insulin.

SISTER MARGARET CARMELA, former superintendent of St. Joseph's Hospital, Yonkers, N. Y., died in that institution at the age of 63. She was identified with St. Joseph's for three years, retiring a year ago because of ill health. Prior to that she was associated with St. Vincent's Hospital in New York for thirty years.

LULU BOWERS is the new superintendent of Morris Hospital, Morris, Ill., replacing AMY HOLTORF who has resigned after twenty-six years of service with the hospital. Miss Bowers was superintendent of Horatio N. Woodward Memorial Hospital, Sandwich, Ill., for ten years.

KATHERYN BRADY has been appointed superintendent of nurses at New Jersey State Hospital, Marlboro, N. J. She was formerly assistant superintendent of nurses at Norwalk General Hospital, Norwalk, Conn.

SISTER M. HELENA, who founded the Holy Family Hospital, La Porte, Ind., in 1908 recently observed the golden jubilee of her religious profession. She resigned as prioress of the institution two years ago on account of poor health.

MRS. NELLIE LEES is the new superintendent of Yarmouth Hospital, Yarmouth, Nova Scotia.

DR. E. S. LOIZEAU has been appointed superintendent of the San Diego County Hospital, San Diego, Calif. He succeeds DR. C. E. SISSON whose resignation was accepted several months ago.

DR. ANDREW SMITH, chief of staff at Knoxville General Hospital, Knoxville, Tenn., for the past three years, has been appointed superintendent of the hospital.

JEAN I. GUNN, O.B.E., superintendent of nurses, Toronto General Hospital, Toronto, Ont., was recently awarded the Florence Nightingale medal by the Lieutenant Governor of Ontario. The medal is awarded biennially by the International Committee of the Red Cross at Geneva for conspicuous nursing service.

FLORENCE E. HODGINS, superintendent of Cottage Hospital, Pembroke, Ont., will resign from her position in the fall to be married, when a new superintendent will be appointed. A dietitian will also be chosen at that time. BESSIE CARSWELL who was night supervisor of the hospital has recently been made assistant superintendent.

MRS. ELMER LAVERY is now superintendent of Canastota Memorial Hospital, Canastota, N. Y., succeeding MRS. MARGARET SWEET who recently resigned.

DORIS SHAW, assistant superintendent of Sarnia General Hospital, Sarnia, Ont., is serving as acting superintendent in charge of the nursing staff in place of MINNIE LEE, resigned.

DR. CHARLES W. SELOVER, superintendent of Oakmount Sanatorium, East Bloomfield, Holcomb, N. Y., died July 27. He had been superintendent for about fourteen years.

MRS. F. I. CLOTFELTER has resigned as superintendent of Hillsboro Hospital, Hillsboro, Ill., after serving as hospital head for five years. MRS. AMOS DORT is filling the vacancy.

THOMAS J. GRIFFIN has been named superintendent of Attleboro Springs, Attleboro, Mass., a convalescent hospital operated by the New England Deaconess Association. He succeeds GEORGE S. BROWN.

MRS. EDNA NELSON, superintendent of Ryburn Memorial Hospital, Ottawa, Ill., has become superintendent of Women and Children's Hospital, Chicago. She will be succeeded at Ryburn by BERNICE CLASSON, who will serve as acting superintendent.

H. L. DOBBS has been appointed to serve as acting superintendent of Kentucky Baptist Hospital, Louisville, Ky., following the resignation of GEORGE E. HAYS which took place in July. Mr. Dobbs came to the hospital as assistant superintendent last April.

CHARLES F. NEERGAARD, hospital consultant, New York City, has been elected trustee and chairman of the committee on management of the Neurological Institute, one of the units of the Columbia - Presbyterian Medical Center, New York City.

DR. A. D. FOSTER, medical director of the U. S. Marine Hospital, Chelsea, Mass., has been appointed medical director of the Marine Hospital at Portland, Maine, to succeed DR. JOSEPH R. RIDLON who has been transferred to the U. S. Marine Hospital, at Galveston, Tex.

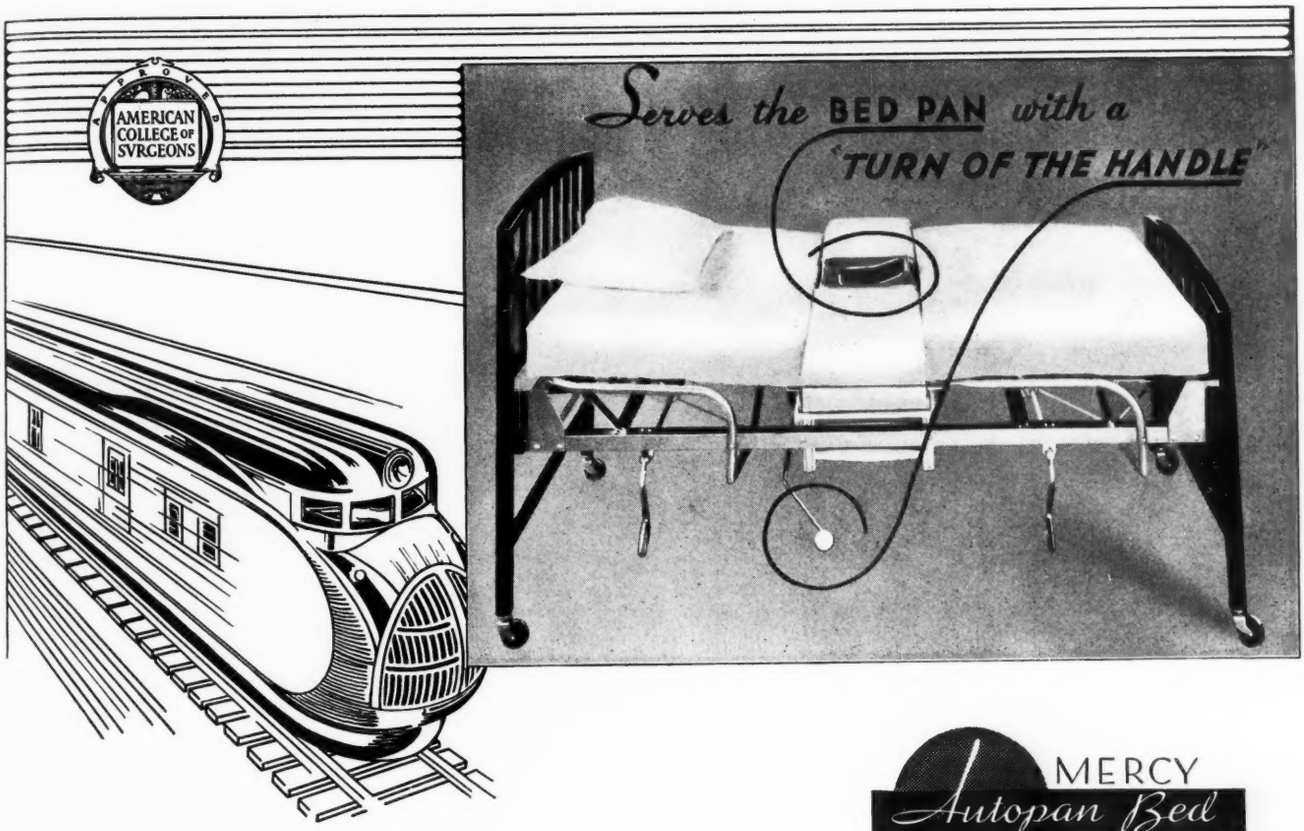
WILLIAM A. RILEY of Stevens, Curtin & Mason, architects, Boston, has been appointed hospital consultant for the new 1,200-bed city hospital at Stockholm, Sweden, for which HJALMAR CEDERSTROM, Stockholm, is the architect. Mr. Riley sailed for Europe about a month ago.

DR. D. P. MATTHEWSON has resigned as superintendent of Pleasant Valley Sanatorium, Bath, N. Y. on account of ill health. He has been superintendent for seven years. His resignation takes effect September 1. Dr. W. W. Bachman has been appointed to succeed him.

DR. CHARLES S. LITTLE, superintendent of Letchworth Village, New York State's institution for mental defectives at Thiells, N. Y., recently celebrated twenty-five years of service at the colony. Dr. Little came to the institution in 1910 and lived in a tent while the first buildings were being constructed. When the eleven buildings now under construction are completed only two more will be required to finish the building program, which will provide care for 3,650 patients at a cost of $10,000,000.

JOE E. GRUNDY has been appointed superintendent-manager of Marion City Hospital, Marion, Ohio.

The Spirit of Progress Modernizes the Surgical Bed



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DR. RALPH H. MAJOR, professor of medicine at the University of Kansas school of medicine, will be the director of the department of medical research recently established at Bell Memorial Hospital, Kansas City, Kans. The department will be carried on as a part of the work of the school of medicine.

DR. GEORGE W. MILLS, formerly superintendent of Brooklyn State Hospital, Brooklyn, N. Y., has become superintendent of Creedmor State Hospital, formerly a division of Brooklyn institution but recently made separate by legislative enactment.

MABEL PITTMAN has become superintendent of the Home and Hospital, Findlay, Ohio. She was at one time superintendent of Van Wert Hospital, Van Wert, Ohio.

EDNA MYERS, R.N., for two years superintendent of nurses at Wilmer Ophthalmological Institute which is connected with Johns Hopkins Hospital, Baltimore, will assume the superintendency of nurses at Rhode Island Hospital, Providence, R. I., September 1. She succeeds HELEN O. POTTER, superintendent of nurses for eight years, who resigned to continue professional study of administrative procedure at Columbia University for a year.

MRS. LUCILLE BROOKS, who has for the last two years been superintendent of the recently closed Kingsport General Hospital, Kingsport, Tenn., has accepted a position with the Halston Valley Hospital, Kingsport.

DR. J. F. MORSE, for ten years medical superintendent of Iowa Sanitarium Hospital, Nevada, Iowa, died August 8.

ELIZABETH HARDING, who has been the dietitian for the last four and a half years at Lakewood City Hospital, Cleveland, is now superintendent of the hospital.

DR. ESMOND R. LONG, director of the laboratory of the Henry Phipps Institute of the University of Pennsylvania, Philadelphia, has been made director of the institute.

SISTER AGNELA, who for the last three years has been supervising dean of St. John's Hospital school of nursing, Springfield, Ill., has been named Mother Superior in charge of St. Clara's Hospital, Lincoln, Ill., it was announced recently by MOTHER MAGDALENE, Superior Sister of the hospital, Sisters of St. Francis. Sister Agnela's position will be taken over by SISTER THEODISTA.

KATHERINE SMITS is the new superintendent of Peninsula Community Hospital, Carmel, Calif., succeeding MRS. DIXIE GOSROW. This hospital was formerly known as Grace Deere Velie Clinic.

MRS. LYDIA A. MARTINSON, Portland, Ore., has been chosen as superintendent of the Brinning Memorial Hospital soon to be completed at Dayton, Wash. The hospital was made possible by money donated by John Brinning, pioneer resident, and by state work relief funds. The equipment and furnishings are being given by individuals and local organizations.

DR. LOUIS A. WESNER, Johnstown, Pa., has been named medical director of the Pennsylvania State Sanatorium for Tuberculosis, No. 2, Cresson, to succeed DR. THOMAS H. A. STITES.

DR. LAWRENCE K. KELLEY of Peabody, Mass., has been appointed superintendent of Tewksbury State Infirmary, Tewksbury, Mass.

MABLE J. HUGILL has been appointed assistant superintendent of the Shriners Hospital, Spokane, Wash.

SISTER M. JUSTINE, R.N., has been appointed Superior of Holy Cross Hospital, Chicago, and SISTER M. DOROTHEA, R.N., superintendent.

Goes to Quincy City Hospital

Dr. Joseph P. Leone, assistant superintendent and admitting physician at Rhode Island Hospital, Providence, R. I., has resigned, effective September 15, to assume the superintendency of Quincy City Hospital, Quincy,

Mass. Doctor Leone is thirty-three years old and a graduate of the University of Rochester. He was assistant director of Strong Memorial Hospital, Rochester, N. Y., 1929-30, under Dr. N. W. Faxon. Quincy City Hospital is a 300-bed institution and Doctor Leone succeeds Mildred Constantine.

Doctor Davis Honored

The officials of Columbia University, at the convocation June, 1935, announced the award to Dr. Michael M. Davis of the Squires Prize for original investigation in the field of sociology. The award is made once every five years, on recommendation of a faculty committee representing the fields of social science, to a graduate of Columbia University who has done outstanding work of a sociologic character. In announcing their decision the committee made special reference to Doctor Davis' book "Paying Your Sickness Bills," published in 1931 by the University of Chicago Press, and to recent articles dealing with health insurance. The prize is the five-year income from a fund established in 1895 by Grant Squires, an alumnus of Columbia University.

Examination to Be Held in October

The next semiannual examination conducted by the registry of technicians of the American Society of Clinical Pathologists will be held in October. Applications should be filed not later than September 15. The last examination was taken by 439 applicants. Of that number 403 passed. The requirements for a certificate are explained in a booklet issued by the registry, which will be sent free on request to the Registrar, 234 Metropolitan Building, Denver.

N. Y. Memorial Hospital May Move

Either its clinic or the entire plant of the Memorial Hospital for the Treatment of Cancer and Allied Diseases will be moved to an east side site opposite the Rockefeller Institute for Medical Research in New York City, according to present plans. The extent of the move depends upon financing. Plans for a complete unit comprising an eight-story hospital building to cost $2,500,000 have been filed, but definite decision in the matter will not be made immediately.

Psychiatric Nursing Course Starts

The second postgraduate course in psychiatric nursing which was instituted for the first time at St. Francis Hospital, Pittsburgh, last January begins September 9. The first of these postgraduate courses in theory and practice in the nursing of psychiatric patients, available to graduates of accredited schools of nursing, has just been completed. It is the plan to start these classes, which take six months, each January and September.

Grisette Heads N. C. Group Savings

Felix A. Grisette, former director of the University of North Carolina alumni loyalty fund, has been appointed executive manager of the North Carolina Hospital Savings Association, it is announced by Dr. I. H. Manning of Chapel Hill, president of the association. Mr. Grisette, as director of the alumni fund, put into operation a fiscal promotional plan that has been adopted by several state universities. The North Carolina plan follows three years of study.

READER OPINION • • • •

"Operating Room Secrets"

Sirs:

I have just read with interest the semi-editorial comment on page 48 of the August issue of The MODERN HOSPITAL in regard to insisting on written consent for operative procedures on patients admitted to hospitals. One or two of our local hospitals, I am told, have for some years insisted on a similar signature, the signed paper giving free consent to the surgeon to do most anything he pleases with absolute immunity.

A good many years ago, and long before we had insurance companies to protect doctors, I am certain that a similar paper was devised by some New England surgeons for the same purpose, this being particularly for use in fracture cases. It looked as though it would be a pretty good thing, but very shortly, when suits were brought, the courts I think uniformly threw out those signed documents on the simple ground that the signature was obtained "under duress"; and I have not heard of any of those papers for a long while.

I have noticed, however, the frequency with which courts throw out alleged confessions made by criminals and on similar ground that they were obtained as a result of starvation and physical abuse of the one signing; the reason being the same, that they were obtained not by the voluntary act of the alleged criminal but because he was by physical torture forced to it.

Personally it seems to me that the compelling of the signing of such a paper is a virtual confession of weakness on the part of the surgeon requiring it, and is distinctly beneath the dignity and supposed honor of the profession. I have always talked over the full proposed operative procedures with the friends of the patient, and am always glad, indeed, to have some representative of the patient in the operating room: we have no operating room secrets. If anything unexpected turns up, which, of course will happen occasionally, the matter is at once brought to the attention of the visiting friends, as to the necessity of something in addition being done, and that is the end of the whole trouble.

I think it would be wise for you to investigate this matter a little, and I presume that some of your leading judges would gladly give you an opinion as to the validity of such forced documents.

J. F. BALDWIN, M.D.

Columbus, Ohio.

Bequests to Non-entities

Sirs:

As public relations counsel of the New York Hospital we note that on page 116 of your August issue under the heading, "British Party to Visit Hospitals," you have inadvertently referred to the hospital as the Cornell Medical Center. The board of governors are very much distressed about the use of the "Center" name because it can be the cause of great damage both to the hospital and the university in laying bequests open to contest.

I am taking the liberty of enclosing a memorandum on the subject.

May I thank you very much for your indulgence in this matter.

SCHUYLER BRADT.

John Price Jones Corporation,
New York City.

The note to editors and writers is as follows:

"In all stories having to do with the medical project at Sixty-Eighth Street and the East River, please attempt to differentiate between whether the story deals with the New York Hospital or Cornell Medical College, and avoid the use of the term 'Cornell Center'.

"We have been requested to do this because use of the term 'Cornell Center' may injure both the hospital and the college from the standpoint of bequests. A bequest to the 'Cornell Center,' there being in law no such entity, might be upset by other beneficiaries under a will. The hospital built and actually operates the so-called center; on the other hand the use of the word 'Cornell' would leave in doubt the question of whether the testator wished to leave the money for medical education or for hospital work.

"The chief general guide as to whether the name New York Hospital or Cornell Medical School should be used, is whether the story deals with care of the sick or with medical education. John Smith, for instance, is a patient in the New York Hospital, while Dr. Charles R. Stockard is professor of anatomy in Cornell Medical College. Incidentally, the old Cornell Clinic was taken over by the New York Hospital when both institutions moved to the new buildings. The building as a group should be referred to as the New York Hospital, as the hospital in addition to building and operating them, occupies approximately nine-tenths of their total space."

Medical and Health Centers?

Sirs:

You asked me to discuss the June issue of the *Architectural Record* which is devoted to medical and health centers.

To most of us the term medical center implies the combination of medical school and hospital, but the text and illustrations would seem to indicate that the medical school is not a necessary item, and that even the inclusion of the training school for nurses is questioned.

Of the hospitals chosen for illustration three by Ellerbe & Company are medium sized buildings erected at an extremely low cost per cubic foot. In general the ward and private floors are not badly planned although the serving kitchens appear too small, and the use of inside stairways and even utility rooms on certain floors appears inexcusable. The planning of operating rooms, with so-called workrooms, which appear to be a combination of scrub-up and sterilizing rooms, between each pair of operating rooms, is hardly in accord with modern practice.

The hospitals designed by the office of John Russell Pope in association in one case with Dwight James Baum and in the other with William F. McCulloch, with Dr. S. S. Goldwater as consultant in the latter case, are far more representative of modern hospital planning.

Some may criticize the omission of lavatories in bedrooms of the nurses' home and others the dark waiting room on the x-ray floor of the Meadowbrook Hospital, and most will regret the attempt to carry the pilaster treatment across the façade of the patients' building behind the continuous balconies. At Syracuse the location of staircases and the elevators opening on a relatively narrow corridor might be criticized, as well as the arrangement of the utility room, but the operating service is well planned.

Finally we come to the great Los Angeles County General Hospital, acute unit, designed by the Allied Architects Association of Los Angeles, in which all hospital men are interested. Alas, this important structure is illustrated by exactly six plates, one of which shows merely concrete texture! The entire number might well have been devoted to this unit, with accompanying text. For a group as complicated as this it would be intensely interesting to have a full description of the method of administration, routing of patients, preparation and distribution of food and other important details. There should certainly be some explanation offered for the arrangement by which the elevators land in the middle of the ward units, and for the inside utility rooms and the isolated one-bed rooms in the "A" ward units.

When the plans are studied with a magnifying glass the placing of beds in the smaller wards appears difficult to say the least, and no plans are furnished of maternity, isolation or operating floors, and no details of any portions. The single view of the impressive exterior of this hospital makes us regret the absence of photographs from other points. It is regrettable that a group of this importance should be published so inadequately.

Following this, two pages are devoted to diagrammatic models of a hospital city at Lille, France. It seems a pity, since the successful competition drawings for this hospital group by Walter, Madeline & Cassan of Paris were published last February, that they were not shown rather than a fanciful twenty-four-story sketch. The plan of the operating unit with projection screen and observers placed in an adjoining room is, of course, of interest.

Finally, the Pioneer Health Center in London shows a type of building, simply planned, which should give excellent service not only for health but for recreation as well.

The Los Angeles County Health Centers are interesting as is the descriptive article which accompanies the plans. It is regrettable that the very charming sketches of these buildings appear to bear so little relation to the plans.

The text of this special number contains an article by George S. Holderness on medical centers, small and large. He describes first a medical center containing many special divisions, for a community of 25,000. To the writer it appears more than doubtful whether any community of that size could hope adequately to staff or maintain such a group, even if it were justified in erecting the necessary buildings.

The suggestion that tuberculous patients might be cared for in the isolation hospital would hardly appeal to those familiar with modern tuberculosis technique.

The latter portion of the article, treating of the larger community is of real value. The point made by the author that often certain of the units comprising the medical center may be already in existence, and actually under separate management, and that these should be brought into the general group, even though they retain their identity, is worth considering, especially by committees which feel that they must build new even at the risk of furnishing competition in a field already covered.

The tabulation of the elements of a hospital, also by Mr. Holderness is of great interest, and is made more useful by the copious illustrations. There are, of course, some omissions as there must be in any such list and with some items we may not be in accord, and some we may consider to be treated inadequately, but the list is one that will be of value to all who are interested in hospital construction; may I recommend to all such, that they study it with care and add their own suggestions and criticism. When they have done this they will have an excellent check list for future reference.

Clyde Place's article on mechanical and electrical equipment is of real interest and with Mr. Holderness' article forms a complete whole.

As a whole, however, this number of the *Record* is a distinct disappointment.

CHARLES BUTLER.

New York City.

Shortage in the South?

Sirs:

Do you mind a waste basket thought on your recent editorial "Fairness to Nurses"?

We are experiencing what appears to be the beginning of a real shortage of graduate nurses in the South. I have previously seen the same situation developing in Wisconsin and Miss Larson of the Medical Bureau tells me that she has noticed a marked increase in the demand for graduate nurses. Perhaps the day of the graduate nurse holding a tin cup and wearing dark glasses is definitely passed and the pendulum may be swinging the other way. The closing of schools, increase in occupancy along with the work of the Grading Committee may produce some rapid changes. It may take a good deal of ingenuity on the part of hospitals to keep pace with this movement. I am wondering if an informal survey of some of your readers might not confirm this impression. It might result in something at least newsworthy.

A. J. HOCKETT, M.D.,
Superintendent.

Touro Infirmary,
New Orleans.

The MODERN HOSPITAL will gladly act as a clearing house for information on the supply of nurses in various communities as viewed by hospital superintendents. Readers are invited to send us as unbiased and objective a picture of the situation as possible. Are there sufficient nurses in your community available to meet the demands for special duty in hospitals? For general floor duty service? For specialized types of nursing—maternity, psychiatric, surgical, pediatric, public health home nursing? What remuneration are hospitals offering for the nurses they wish to employ? Are all available and competent nurses on the registries? Do the hospitals employ only graduates of certain schools or will they take any able nurse?—Ed.

Sealex Linoleum in the ward of St. Barnabas Hospital, Newark, New Jersey. Aside from its decorative value, the one-piece rounded cove base installed at the junction of walls and floors makes this floor 100% sanitary—ideal for the hospital.

Choose Sealex . . . *to give your hospital floors this modern sanitary advantage*

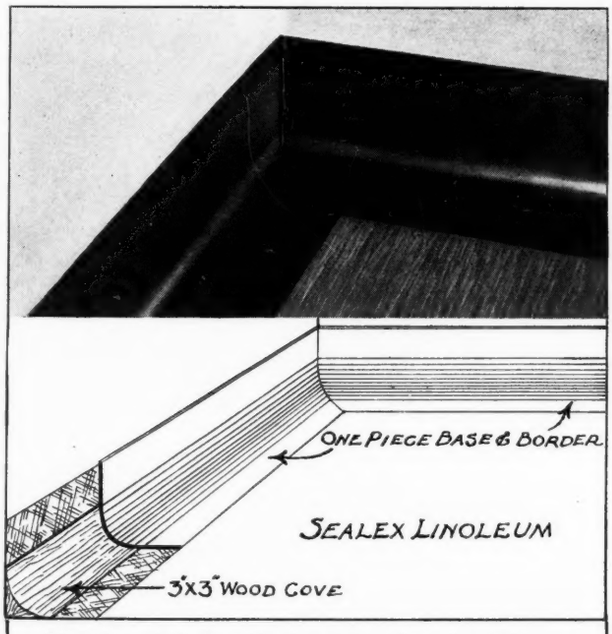

Diagram and photograph of a corner of the hospital ward above, showing "close-up" views of the sanitary cove base and border which was installed with the Sealex Linoleum Floor.

This Sealex Linoleum Floor has been installed with a sanitary one-piece cove base and border at the point where walls meet floor. This modern improvement—unlike the ordinary mop-board or cement base—eliminates dirt-catching angles and hard-to-clean corners.

The one-piece cove base and border treatment—widely used throughout modern hospitals because it makes thorough cleaning quick and easy—adds but little to the moderate cost of a Sealex Linoleum Floor. And Sealex comes in a wide variety of cheerful patterns that can be laid quickly over your present wood or cement floors. No costly preparation.

Although quiet and comfortable underfoot, Sealex is a long-lived wear-resisting floor—easy and inexpensive to maintain. When installed by authorized contractors, both materials and workmanship are backed to the full value by a Guaranty Bond. Write for full information about Bonded Floors for your hospital.

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LITERATURE *in* ABSTRACT • • •

Conducted by E. M. Bluestone, M.D.

Purchasing Problems From the Executive's Viewpoint

The first major obstacle hampering executive control of purchasing is the amount of unrecorded current detail involved in the purchase of food, and the fact that this detail must be carried out in a relatively short period, usually a few hours. The executive's approach to this phase would be to determine the most important factors involved, which, in purchasing, are those commodities for which the most money is spent.*

The second phase of the purchasing problem from the executive's viewpoint is control of quality. The first steps that the executive will take will be to substitute standard specification for the loose term "quality." The desirable "quality" for a product should be determined by the use to which it is put and by the results expected by it.

The third obstacle which has retarded the development of executive control of purchasing is the difficulty of measuring in dollars the results accomplished. The executive should expect that the normal performance of the purchasing function provides that the purchase price for any commodity should increase or decrease simultaneously and to the same extent as any advance or decline in the general market price of that commodity.

Savings or an increase in purchasing efficiency can be claimed only when the purchase price shows an improvement in relation to market fluctuations.

*Graham, L. I.: How Food Costs Can Be Reduced by Executive Control of Purchasing, Rest. Management 36: 309 (May) 1935. Abstracted by Katherine Reamer.

What Constitutes Hospital Efficiency?

Walter* sketches the history of the development of the hospital from the early days of the priest-temple through the asylums for the care of paupers to the hospital of the modern era. A consideration of efficiency and economies in the modern hospital includes a much broader concept than financial savings. More important are improved medical service to the patient, lowered death rate and decreased length of hospital stay.

The last type of increased hospital efficiency has been accomplished by the application of the newer methods of diagnosis and treatment. Hospitals have been pioneers in the use of new and expensive equipment and special departments such as electrocardiograph, basal metabolism, physiotherapy, x-ray, diet therapy and oxygen therapy. Another example of increased hospital efficiency is the more thorough utilization of the great educational resources of the hospital during recent years. Around the hospital now center the fifth year training for interns, the practical and didactic instruction of the student nurse and the pursuit of advanced training for the practitioner of medicine in postgraduate courses.

The last decade has also witnessed an increased application of modern business methods in the financial affairs of the hospital. Purchasing is becoming a more standardized procedure. Modern accounting methods are being adopted in an increasing number of hospitals. Standards for the training of hospital administrators are being set up by the American College of Hospital Administrators.

Many need hospital care but are unable to pay for this care. At the same time hospitals have empty beds. The problem is to find some means of financing a method by which all who need it can purchase care.

*Walter, Frank J.: Innovations in Hospital Service Conducive to Efficiency and Economy, Bull. Am. Coll. Surg. 20 (June) 1935. Abstracted by M. Jandon Schwarz, M.D.

Room Upkeep in One Hotel System

In the office of the head housekeeper of the Detroit Statler Hotel is a record of each room giving exact information as to when it was painted, washed, draped, furnished.*

When inspecting a floor for reconditioning purposes the building maintenance head accompanies the housekeeper. Together they check every detail, making a written record of their recommendations. These are then submitted to the manager and in consultation with him a decision is reached. For renovating, the sections in which the room or rooms are located are temporarily shut off.

Wall paper is removed with a steamer taking one man seven hours to do one room. The Statler system uses a commercial cleaner in washing the walls, washing from the bottom up and removing the cleaner with clear water, washing from the top down. This method avoids streaks.

Ceilings are repainted with a white paint of 50 per cent white lead and 50 per cent white zinc. A stipple finish is used on the second coat. The tile man inspects the bathroom tile, at the same time going over all tiled surfaces, repainting and replacing broken tiles when this is necessary. The carpenter tests windows to make sure that they may be raised and lowered properly. He also inspects doors, trims and moldings.

Draperies and curtains are cleaned more frequently than rooms are reconditioned. The glass curtains are washed every week in a cream tinted dye. The draperies are cleaned every other month or when needed. Furniture is remade or recovered in the upholstery shop. Mattresses are renovated in the hotel shop. Carpets are scrubbed on the floor with the aid of a carpet washing machine.

A thorough inspection is made after the room has been completely renovated.

*Anonymous: Housekeeping on Parade, Hotel Month. 43: 24 (Apr.) 1935. Abstracted by Viola Lukofsky.

Why the Tuberculous Should Be Treated in General Hospitals

Patients suffering from tuberculosis can and should be treated in general hospitals, as well as in sanatoriums, according to Myers,* who demonstrates conclusively the therapeutic, economic, social and educational advantages to the patient, community, general hospital and physician from such an arrangement.

Centuries ago "consumptives" were freely admitted to general hospitals, usually, however, for palliation and isolation prior to death, because this disease as a rule was not diagnosed until the late stages.

Bodington of England conceived the idea of sanatoriums for the tuberculous. Brehmer and Dettweiler in Germany and Trudeau in this country so successfully developed this form of treatment, that it has undoubtedly been and will continue to be instrumental in reducing the mortality and morbidity of this disease.

With the advent of sanatoriums most physicians lost interest in clinical tuberculosis and general hospitals refused to accept such patients on their wards. Through the efforts of the National Tuberculosis Association, beginning in 1916, and subsequently of Surgeon General Hugh S. Cummings, the American Medical Association, the American Hospital Association and many nationally known tuberculosis workers, interest in this problem was revived and as a result in 1934 more than 40,000 "consumptives" were treated in general hospitals.

Objections raised to this method of caring for the tuberculous can readily be proved groundless. Families well able to pay the private hospital expect no free service when one of their

Who left that bag of sugar out in the rain ?

WASTE *like this couldn't happen in your kitchen*

..but **WASTE** from out-dated equipment goes on unheeded

It's easy to spot wastes before your eyes—but it's hard to nail the wastes that work under cover. That's why a lot of ranges which have been around for years are allowed to go on eating up profits.

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members is ill with any other acute or chronic illness and will ask for no such service when that one is ill with tuberculosis. The general hospital can give as good general care, which includes rest, fresh air and proper diet, as the sanatorium. The special measures for collapsing and resting the diseased lung, namely, artificial pneumothorax, phrenicectomy (or cutting of phrenic nerve) and extra-pleural thoracoplasty (or removal of ribs) can all be performed in the general hospital by men trained for such work. The danger of contagion to patients, nurses and students of medicine can readily be obviated by rigid contagious disease technique. Among the numerous advantages to the general hospital are an increased income and the use of a consultation chest service.

There are in this country about twice 700,000 cases of tuberculosis that need immediate treatment, if we consider the preclinical cases. The 80,000 available sanatorium beds are insufficient for the rapid care of so many patients. Since the mortality and morbidity and the number of potential cases of clinical tuberculosis are decreasing, it seems poor economy to build new sanatoriums. It would be far wiser to utilize the 150,000 vacant beds in general hospitals, and have patients pay who can afford to do so; those who cannot should have fees of hospitals paid from tax funds.

*Myers, J. Arthur: Function of the General Hospital in the Treatment of Tuberculosis, Proc. Annual Congress on M. Ed. Feb. 18, 1935. Abstracted by Morris J. Robin, M.D.

What the Trustee Should Know

Bowditch* points out that the trustees are responsible for the policies of the hospital. They should therefore be willing to give some time to learning whether these policies are being efficiently carried out. Some basic standards are available by which the trustee can determine the hospital's general status. Is it approved by the American College of Surgeons? Has it been approved by the American Medical Association as providing adequate training for interns? Is the school of nursing approved by the state board of registration?

In studying the efficiency of a hospital, the bookkeeping department is an excellent place to begin. The daily census will reveal variations in the demand for service. The treasurer's monthly statement will show interesting facts with regard to disbursements and variations in income. Interesting facts about percentage of patients discharged "improved" and about mortality rates can be obtained by a conversation with the record room clerk. Informal conversations with the physicians will reveal new points of view. In addition, there should be regular meetings of the medical and surgical staffs with the board of trustees.

An excellent way to learn whether the hospital is filling the needs of the community is to read letters written to the director by discharged patients. They often reveal points that should be investigated. Trustees should attend local hospital association meetings and if possible the meeting of the American Hospital Association, in order to compare experiences and learn what other hospitals are doing. A trustee can, moreover, secure information by joining groups of visitors making a tour of the hospital.

*Bowditch, Ingersoll: How I, as a Trustee, Judge the Efficiency of Our Hospital, Bull. Am. Coll. Surg. 20 (June) 1935. Abstracted by M. Jandon Schwarz, M.D.

Handling Frozen Products

Freezing at as low a temperature as may be practicable, combined with quick hardening, gives the smoothest product.* There are two stages in the freezing process — the actual preliminary freezing with brine circulating, and the whipping period during which the brine is shut off and the whips are released to beat up the mix to the desired overrun.

The temperature of the mix should not be more than 40° F. and should preferably be 27° F. when the mix is entering the freezer. The temperature of the brine should be from 5° F. to 10° F. down to 10° F. to 15° F. Freezing at 10° F. to 15° F. is possible in the new rapid freezers, and sharp scraper blades permit drawing at a low temperature. The higher the proportion of water in the mix frozen into crystals before drawing, the smoother the ice cream if the freezing is done by this new rapid process.

Slow freezing may be due to defects or difficulties in the brine or ammonia system. It may arise from a mix of too high a sugar content or from mechanical defects in the freezer itself. Slow whipping will result chiefly from faulty proportions used in the mix formula and the manner of processing.

The maximum temperature for fast hardening is 10° F. and the minimum is 25° F. Electric fans are used to hasten the hardening process by increasing air circulation in hardening rooms of sufficient size and where the time element is a factor.

Special care should be given to all details of the handling and dispensing of the frozen product to save shrinkage. It is an important asset in developing and maintaining business to use standardized methods and processes yielding dependable, uniform products.

*Handy, Etta H.: Economical Ice Cream Production—chap. 4, Freezing, Hardening and Dispensing of Frozen Products, Hotel Month. 43: 30 (May) 1935. Abstracted by Altha Wingo.

The Story of the Pineapple

Pineapple was grown as early as the fifteenth century in France and in 1668 it was considered a delicacy in England.* The plants were not taken to Hawaii until 1813, when they were brought from Mexico by a Spanish sailor. Captain John Ridwell, an English horticulturist, organized the first pineapple canning company, known as the Hawaiian Fruit and Packing Company.

The pineapple plant develops in twenty-two to twenty-four months from a "slip" which is taken from the fruit or plant. One plant produces from three to four crops, after which the field is again plowed and replanted. The heaviest season for pineapples is from June to September, although they grow and ripen the year round. In canning, it takes just three and a half minutes for the pineapple to go from the peeling machine to the cooker.

Among canned goods, the pineapple is probably the most uniform because there are only nine Hawaiian pineapple canners and they all follow grade specifications.

A chart has been compiled which analyzes the various grades and types of canned pineapple, together with their comparative costs. The types are as follows:

Sliced, broken slices and pieces, tidbits, crushed and natural unsweetened juice. It may be of interest to note that the No. 10 can with 50 slices per can is the most economical of the various sizes in slices.

*Scott, William A.: Hawaiian Pineapple—the King of Fruits, Hotel Management 37: 310 (Apr.) 1935. Abstracted by Elizabeth Cole.

Utilizing Employees' Suggestions

The author* points out that the possibilities and advantages of suggestions for improvements emanating from employees may be developed to a greater degree, though some success has been attained along these lines. The success of a suggestion system is gauged by the average number of worthwhile suggestions per employee per annum.

The highest figure attained in one organization (the author's) was 5.8 suggestions per employee per annum, which the author considers low. It is interesting to note, however, that the next best record was only 0.6. No system can be successful unless a major official of the organization is actively promoting it. Publication of adopted suggestions in the monthly organization periodical, if there is one, will act as a stimulus; in industry it serves as a vehicle of advertisement. Suitable prizes may be given, preferably in cash, for suggestions that are adopted.

The suggestion investigator must

Owens, Illinois and Royal prescription ovals supplied in all standard sizes.

Emerald Green Powder Jars, Dropper Service, Ointment Jars, Capsule and Tablet Containers.

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● Progressive hospitals, building prestige with fine administration and fine service, also consider it important that the prescription package which the patient takes home make a final favorable impression. This prescription may be seen daily in medicine cabinet or on the bedside stand for many weeks. The doctor sees it, too, when he calls. Clean, crisp, ethical appearing Owens-Illinois prescription ware continues to reflect credit on the hospital long after the patient has been discharged.

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tactfully explain to unsuccessful suggesters the reasons for rejection. He should have the confidence of the personnel and advise with them on any contemplated suggestions they may be considering. A suggester's right to appeal for reconsideration should always be recognized. Undue delay in making awards for accepted suggestions leads to discouragement. Credit should be given to an employee when his suggestion is adopted, even though the original suggestion may be somewhat modified by the organization.

The opportunity to submit suggestions provides a means of self-expression for the employee, adds new interest to his work and fosters the habit of observation. The cumulative effect of many minor suggestions soon becomes apparent and results in raising the standards of the organization. A suggestion plan gives the employee an opportunity to reveal latent ability and earn promotion.

*Sam Mavor: What's Wrong With Suggestion Systems? Executives Service Bull., July, 1935. Abstracted by J. Goodfriend.

Meeting the Problem of Cancer

The committee on the treatment of malignant disease of the American College of Surgeons reports on the purposes, organization and scope of cancer diagnostic clinics.*

With our present resources of surgery and radiation it is held that the majority of cases of early local cancer can be cured. For the advanced cases only palliation can be offered. From this it follows that the crux of the problem of malignant disease rests with early diagnosis. The field of cancer diagnosis and treatment has developed so widely during the past few years that it is only by the combined efforts of the various special departments of the hospital that the full resources available today for the detection and treatment of cancer can be brought to the patient.

The organization and scope of the cancer clinic will depend upon local conditions. In metropolitan communities where high voltage x-ray machines and radium are available, a complete therapeutic, as well as diagnostic, service can be given. In the smaller communities the cancer diagnostic clinic may perform an important service. It will enable earlier and more accurate diagnosis; it will furnish a collective judgment upon which therapy may be based; it will educate the medical community in this important group of diseases.

The practitioner should be encouraged to send his patient to the clinic. When a diagnosis has been reached and a course of therapy outlined, the patient will be sent back to the referring physician. An important function of the clinic is the periodic conference at which interesting cases are presented, ideas concerning therapy exchanged and pathologic material presented. Thus the cancer clinic will serve as an important educational center in addition to ensuring the best available medical care for the cancer patient.

*Cancer Diagnostic Clinics, Bull. Amer. Coll. Surg., 20: 72 (June) 1935. Abstracted by M. Jandon Schwarz, M.D.

Requirements of a Thirty-Five-Bed Hospital

Hatcher discusses the problems of the thirty-five-bed hospital.* The first question that arises in the problem of the rural hospital is "Do we need a hospital in this community?" The second, "What bed capacity can this area support?"

Adequate equipment is just as vital in the small institution as it is in larger hospitals. There must be facilities for complete diagnostic service in all departments. Even the small hospital must have x-ray, laboratory service, basal metabolic equipment, oxygen therapy and thoroughly equipped operating rooms.

If obstetric cases are to be accepted there should be a maternity division apart from the general medical and surgical cases, with a separate delivery room and a nursery.

The hospital must have a well trained staff chosen from the best practitioners of the community. In small communities it is generally understood that any member of the local medical society is qualified and should be permitted to perform any kind of surgical or medical feat he chooses. This has occasionally resulted in tragedy and remains an unsolved problem of the small hospital. Nursing service presents its own problem in the small hospital. Shall graduate nurses only be used? Shall a training school be conducted, or shall maids be employed as is sometimes done in the small hospital? The author believes that a training school for nurses has no place in the small hospital.

*Hatcher, A. R.: Problems of Hospitals in Small Towns and Rural Areas, Bull. Am. Coll. Surg. 20 (June) 1935. Abstracted by M. Jandon Schwarz, M.D.

Accounting Policies

In this article* the author brings out the interesting fact that charitable institutions in California must obtain permission from the attorney general to accumulate income. The purpose of this is doubtless to make sure that corporations of this classification will not curtail the charitable activities for which they were created and divert accumulated income for improper purposes.

Inasmuch as the amount of accumulated income is dependent on accounting policy, the author suggests the following procedure:

Profits or losses on capital assets should be included in the computation of "Accumulated Income."

A reasonable rate of depreciation on buildings merits a place among the expense items.

The practice of charging purchases of equipment and furniture to "Expense" in lieu of capitalizing such items is apparently a more or less recognized procedure of this type of corporation, although of course from the strictly accounting point of view it would not be permissible.

The respective merits of the cash and accrual basis do not appear to be of great importance in this connection, provided proper segregation is made as to Income and Capital Receipts; Expenses and Capital Expenditures. The author is of the opinion that the cash basis might possibly be the better for the reason that if the accrual basis were used, it would be necessary at the end of the operating period to set up Accrued Interest on Bonds and, in these days of defaults, it might be safer to await the receipt of interest before regarding it as "Income."

*Strangman, Arnold H.: Accumulation of Income by Nonprofit Corporations, Certified Public Accountant, July, 1935. Abstracted by Simon Tipperman.

Health Insurance for Health Conservation

The author,* who is the scientific director of the Milbank Memorial Fund, approaches the problem of health insurance from the viewpoint of health conservation rather than from that of economic security, yet the article implies temporal and personal distribution of the financial burdens of wage loss and medical cost.

The concept of public health is historically developed, and its future implications defined, with emphasis on the fact that no particular form of government or specific method is necessary. It is significant that there is a high inverse correlation between income and high mortality and morbidity rates. The existing economic system must be considered in devising a method for distributing care.

The two types of insurance suggested are (a) against loss of wages resulting from ill-health and (b) against the cost of medical care, each to be administered separately. They should be national in scope; compulsory unless a voluntary system can be evolved; the family rather than the individual should be the unit, and the control of personnel, services and practices should be by the medical profession.

*Sydenstricker, Edgar: Health Insurance and the Public Health, Academy of Political Science, 1935. Abstracted by Harold Kelman, M.D.

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treatment

YOU KNOW the mental value of cheerful decoration in sick rooms, but do you know that Goodall printed mohairs also give your *expense budget* a rejuvenating treatment?

Mohairs need no nursing. Their smooth fibres do not collect and hold dust and dirt. They neither wrinkle, muss, shrink nor sag. They are sun-and-tub-fast. An occasional shaking and a rare washing are all they need to keep fresh. They are more nearly *permanent* than any other decorative fabrics.

Modern hospitals have long depended upon Goodall mohair casement and cubicle curtains for their superb service. These new 32-inch prints have the same qualities, plus pleasing decorative effect. Your jobber . . . or a Chase representative . . . will show them upon request.

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BOOKS ON REVIEW

CITE HOSPITALIERE DE LILLE. *Text in French, English and German. By Paul Nelson. Paris: Editions "Cahiers d'Art,"* 1933. *Pp.* 134. *Illustrated.* $5.

A French hospital designed by an American of Irish descent and a Swedish name should be an event—and it is.

Paul Nelson, the architect, has made a most attractive presentation in this brochure of the Lille medical center project. A glance at the plans reveals its New Deal proportions, though the exact number to be cared for eludes me even after careful reading. The hospital figures are definite enough—1,892 beds, but this is only the beginning. There is a building for aged incurables and convalescents with a capacity of 3,000 beds, as near as I can judge, a building for the "pensioned" of 200 beds, making a total of 5,100 beds for resident guests (patients is hardly the word) and to this are added an army of resident personnel, a medical school, 750 bicycles and 10 funeral chapels—a sizable project for Lille's 400,000 people!

To understand the planning, it must be remembered that the "médicin-chef" is a minor, if not a major, god in the French hospital, so 50,000,000 Frenchmen must be moved to the doctor, never the few doctors to the patients—a Continental concept introduced in this country at Los Angeles County Hospital and the New York Hospital. Hence every clinical unit must be complete in itself, with duplication of little used facilities.

The ingenious operating suite for the private patient building and the care given to the service of supply and to visitors illustrate the clear thinking that Nelson can do when not hampered by tradition or formulas.

An exterior wall is proposed of removable sections of opaque, translucent or clear glass bricks, which may be interchanged at will. The interior partitions are equally movable. None of the sections may be opened for the buildings are to be air conditioned. With such great faith in air conditioning, a new and relatively untried device, it is difficult to understand why Nelson didn't put a little more faith in an older and well tried device—electric lighting and its younger sister, the ultra-violet.

Mr. Zervos, in his introduction, refers to Mr. Nelson's mastery of technical details "without embarrassing himself primarily with esthetic problems." No more complete apology for the exterior is possible.—CARL ERIKSON.

THE HOSPITALS YEARBOOK, 1935. *R. H. P. Orde, B.A., editor. Central Bureau of Hospital Information, London,* 1935. *Pp.* 330.

Some of the differences as well as similarities between British and American hospitals are brought out by a perusal of this interesting volume.

In contrast to American institutions, the British voluntary hospitals generally permit no remuneration to physicians for work done in the hospital, they have a much higher occupancy rate, a much smaller percentage of the income is earned, and the operating costs are lower although they must generally pay taxes on real property.

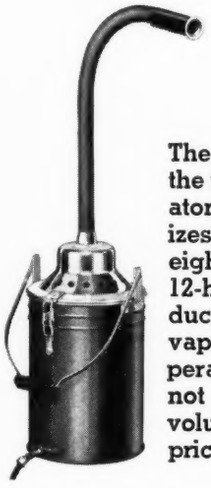
There are in London, the provinces, Scotland and Ireland 1,061 voluntary hospitals, with 85,091 available beds. Comprehensive and valuable data on facilities, extent of use, costs and sources and extent of income are given for 978 of these hospitals.

Mr. Orde devotes a section of his report to the sweepstakes. "There is little doubt that hospitals were wise in their decision to have nothing to do with sweepstakes or lotteries in general," he says.—A. B. M.

Booth 163

See the Ideal equipment displayed at the A. H. A. convention in St. Louis.

Ideal . . . first by merit



The Ideal Inhalator for the treatment of respiratory diseases. Vaporizes from cool water in eight minutes. Has a 12-hour capacity. Produces great volume of vapor at the right temperature. Inhalent does not boil. Has vapor volume control. Low priced.

THE evident leadership of Ideal Food Conveyor Systems (found in foremost hospitals) results from *acknowledged* superiority. Ideal pioneered in systematized hospital meal distribution. It has fostered development by cooperation with hospital executives and the maintenance of an expert engineering, manufacturing and service organization. Just as 20 years ago Ideal was the first recognized food conveyor *system,* so today Ideal is the most advanced. Use the coupon below for information about the new models.

Ideal Stupe Kettle systematizes an important hospital service. Portable—operates at the bedside. Quick, economical, sanitary. Stupes are easy to handle. Insulated—it doesn't heat up the room. No danger of tipping over—no messy hot plates or pans of water. Low priced.

The Swartzbaugh Mfg. Co.,
Toledo, Ohio.

Send me detailed information about the new Ideal Hospital Equipment.

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NOTES *for* BUYERS • •

Diabetic Diets Brought Up to Date

We suspect that diabetic patients have always hoped for more palatable foods, that they haven't really expected such wishes to be gratified. But now, they should really prick up their ears—John Sexton & Co., Chicago, who for many years have featured canned foods prepared without sugar or seasoning, introduce their fruits packed more palatably.

Restricted diets have been especially unappealing when fruits were put up in water. These new Sexton fruits are packed in the juice taken from additional fruit of the same kind. The new method only slightly increases the carbohydrate content (the modern trend of treatment for diabetes, it is said, allows for a higher carbohydrate diet).

The company's canned vegetables are the same as before except that they will appear under the label, "Sexton High Quality Foods for Restricted Diets", rather than the former label, "Alp Rose."

The "How" of Color Motion Pictures

Whether or not color is to be utilized to any extent in medical films we do not know, but a surgeon interested in filming in color the intricacies of a blood transfusion, say, might do well to read "How Color Is Put Into the Movies," the lead article of a leaflet issued by The Electric Storage Battery Co., Philadelphia. A firm known as The Technicolor Company, it is stated, has recently developed a three-color process for reproducing motion pictures in natural colors. The process depends upon a three-color camera which breaks down the complex color-shades of light reflected by the object photographed into the three primary colors and records them simultaneously on three strips of film.

Tale of Two Tissues

They're waging a war on waste, is the news from Straubel Paper Company of Green Bay, Wis. The new Straubel Roll Toilet Tissue positively dispenses two sheets at a time. This is the way such economy is effected: where roll toilet tissue is usually perforated, dividing sheets of uniform size, the paper in this new roll is actually cut (in place of the perforation) at the end of every two sheets, except for a short length at one side. As the paper is pulled from the roll, every second sheet pulls away at an angle, concentrating all the tension at the uncut edge and producing a twisting action which separates the paper before additional sheets can be pulled from the roll. Added movement is necessary to grasp another two sheets—a tiresome procedure. And so human laziness tends to bring toilet tissue waste to the minimum point.

Refrigerator News Flash

And now comes the air conditioned Coolerator to join the refrigerator-of-the-month club and suggests that the ice man may come back into his own. One important feature of these new ice cooled refrigerators offered by The Coolerator Co., Duluth, Minn., is that foods are kept fresh with their own natural juices and flavors. Butter retains its individuality in flavor and does not join forces

with the cantaloupe or the cheese. Food odors are picked up by a continuous natural flow of air and passed through an air conditioning chamber, where they are absorbed and washed away.

Healthfully humidified air that returns to the food chamber several times each minute and a uniformly low temperature are other means of preserving perishable foods. Because only the bottom surface of ice in the Coolerator comes in contact with air, there is less melting. And the happy result, we learn, is that one re-icing every four to seven days is enough. In fact the company claims that there is a substantial saving in operation.

To eliminate those trips to the basement for ice, there is also the Coolerator ice chest for ice packs and other purposes.

•

Accessory to the Nursing Bottle

Babies, we believe, will soon be (if they are not, already) Hygeia fans. It's because the Hygeia Nursing Bottle Co., Inc., 197 Van Rensselaer Street, Buffalo, has done some research on wind-sucking—a condition which is due in many cases to the use of a nipple which does not conform to the shape of the infant's mouth.

No single type of nipple can possibly in itself prevent all cases of wind-sucking, we are told, because of the variation in infants' mouths. Hygeia now presents two new nipples which, with the type previously manufactured by this company, are said to meet every nursing need. They are easy to clean, it is pointed out, and they are molded in a shape that any baby will accept readily. Moreover, we learn that these new nipples resist collapse.

The Hygeia company thoughtfully sends directions for the care of bottles and nipples. Five "do's", aided by three "don'ts," start one off on the proper technique of nursing bottle care.

Trade Catalogues and Pamphlets

New Beauty Treatment for Rugs—"Rugs washed while you wait" might be the slogan of the Hild Floor Machine Co., 1313 West Randolph Street, Chicago. A recently issued booklet illustrating the Hild machine which washes rugs and carpets on the floor, describes the process in detail. A "shower-feed" brush deposits a light film of special shampoo solution which is worked up into a lather. The solution is volatile and evaporates, the manufacturers say, in ten minutes. The same versatile machine, with interchangeable attachments, also scrubs, waxes, polishes and refinishes floors.

The Fun of Knowing About Microscopes—To the aspiring medical graduate, the Bausch & Lomb Optical Company, Rochester, N. Y., offers words of wisdom and a complete line of microscopes in a new booklet—"Microscopes in Medicine." This business of medical study requires a modern microscope of unquestioned precision, the Bausch and Lomb company declares. An interesting feature of the booklet is a photograph of an instrument that has been sawed in two, with a diagram indicating the various important parts. Two companion books are devoted to descriptions of microscope lamps and accessories.

Give a Thought to Heating Specialties—Heating Catalog No. 45 is a news note for this column, from Sarco Company, Inc., 183 Madison Avenue, New York City. This book helps those interested in power plant equipment to gain a working idea of Sarco specialties. It is stated that the use of these products, in accordance with the manufacturer's directions, assures heating systems of utmost simplicity, high efficiency and troublefree durability. Consult

the catalogue for diagrams and descriptions of a vacuum heating system, a vapor heating system, various types of traps, temperature regulators and valves. Also illustrated is the Sarco thermostatic steam trap, designed for hospital sterilizers, blanket warmers and water stills, and widely used, it is pointed out, for steam tables, coffee urns, dish washers and other institutional kitchen equipment.

Gay China as Appetite Inciter—Dietitians agree that patients eat as much with their eyes as with their lips. Their appraising glance at the trays determines in part how much they will eat. Competing with this situation, puzzled dietitians will want to study cards on china, just released by Onondaga Pottery Company, Syracuse, N. Y. One's chicken à la king, they reflect, would look well framed in this pattern suggesting old English chintz, or one's spiced pear would recline gracefully against this background of vivid Oriental colorings. Then, there's the appetite that balks not at the design in the china but at sight of an overloaded tray. Onondaga has a solution to this problem: "Econo-Rim." It's a china made with narrow rims, the better to assure room for every dish on the tray.

Silence Is Decorative—It may not be possible to keep an irritated baby from crying, but it is possible to keep him from being heard all over the hospital. The Armstrong Cork Company, Lancaster, Pa., suggests the application of decorative acoustical materials on walls and ceilings to deaden sound. Another Armstrong product, a washable wall covering, serves to transform a drab, plain room into a "thing of beauty and a joy forever." Forever in the literal sense, as this material is said to last indefinitely. Two new pamphlets setting forth the advantages of Corkoustic and Linowall can now be had for the asking.

Cleanliness With or Without Godliness—People expect it—patients demand it—hospitals give it. What? Cleanliness as it is found nowhere else. Finnell System, Inc., Elkhart, Ind., offer as their contribution to hospital sanitation the Finnell Floor Machine—a handy device which scrubs, waxes, polishes, steel wools and buffs. Silence, says the new descriptive literature from which we gained our information, is a big feature of this machine. A room can be waxed and buffed while the patient continues his healing slumbers undisturbed. The Finnell company also offers a complete line of wax products and maintenance materials.

Back-Siphonage, the Black Cat Across the Path of Health—Back-siphonage, its dangers and ways to prevent it has been the subject of much discussion in hospital circles recently. The Sloan Valve Co., 4300 West Lake Street, Chicago, devotes a section of its new catalogue No. 35 to the Sloan vacuum breaker which, they assert, prevents back-siphonage from any hospital fixture with submerged inlets. The rest of the book is given over to descriptions and illustrations of the various types of flush valves manufactured by this company—all of which can be furnished with the anti-back-siphonage vacuum breaker.

Symbolism—Six little symbols tell the story. They represent warming, cooling, humidifying, dehumidifying, circulating and cleaning. Automatic control of these processes makes satisfactory air conditioning possible. That's the gist of it.

"This Thing Called Air Conditioning" is a neat little book put out by the Minneapolis-Honeywell Regulator Company, 2820 Fourth Avenue South, Minneapolis. The company does not make or sell air conditioning apparatus, so it feels its book is without prejudice for or against any one system. Its interest is in automatic control, in which it has pioneered for fifty years.